2020

Molina Healthcare of Texas, Inc. Agreement and Evidence of Coverage

Molina Marketplace Plan

TEXAS

5605 MacArthur Blvd, Suite 400, Irving, TX 75038

THIS (POLICY, CERTIFICATE, SUBSCRIBER CONTRACT, OR EVIDENCE OF COVERAGE) 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 the company.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

MolinaHealthcare.com/Marketplace

MOLINA HEALTHCARE

Your Extended Family.

LXN201TXMPEOCEN

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.

Language Access

If you, or someone you're helping, have questions about Molina Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1 (888) 560-2025.

Árabe	إذا كان لديك ، أو أي شخص آخر تساعده، أسئلة حول Molina Marketplace ، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث إلى مترجم فوري ، اتصل على 1 (888) 560-2025.
Chino	如果您，或是您正在協助的對象，有關於Molina Marketplace方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1 (888) 560-2025。
Francés	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Molina Marketplace, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1 (888) 560-2025.
Alemán	Falls Sie oder jemand, dem Sie helfen, Fragen zum Molina Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1 (888) 560- 2025 an.
Gujarati	જો તમને અથવા તમે જેને મદદ કરી રહ્યા હોવ એવી કોઈ વ્યક્તિને Molina Marketplace વિશે પ્રશ્નો હોય, તો વિના કોઈ ખર્ચે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1 (888) 560-2025 પર કૉલ કરો.
Hindi	यदि आपके, या आपके द्वारा सहायता किए जा रहे किसी व्यक्ति के Molina Marketplace के बारे में प्रश्न है, तो आपके पास अपनी भाषा में मुफ़्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी भी दुभाषिए से बात करने के लिए, 1 (888) 560-2025 पर कॉल करें।
Japonés	ご本人様、またはお客様の身の回りの方でも、Molina Marketplaceについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1 (888) 560-2025までお電話ください。
Coreano	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Molina Marketplace 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1 (888) 560-2025로 전화하십시오.
Loasiano	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Molina Marketplace, ທ່ານມີສິດຈະໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ຖ້າຕ້ອງການໂອ້ລົມກັບນາຍພາສາ, ກະລຸນາໂທ 1 (888) 560-2025.
Persian-Farsi	اگر شما یا کسی که به آن کمک می‌کنید سؤالی دربارهٔ Molina Marketplace دارید، می‌توانید کمک و اطلاعات را به زبان خودتان و به طور رایگان دریافت کنید. برای صحبت با مترجم شفاهی با 1 (888) 560-2025 تماس بگیرید.
Ruso	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Molina Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1 (888) 560-2025.
Español	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Molina Markeplace tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1 (888) 560-2025.

Tagalo	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Molina Marketplace, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1 (888) 560-2025.
Urdu	اگر آپ، یا کوئی اور جن کی آپ مدد کر رہے ہیں، کے Marketplace Molina کے بارے میں کوئی سوال ہوں تو آپ کو بغیر کسی قیمت کے اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کیلئے 560-2025 (888) 1 پر کال کریں
Vietnamita	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Molina Marketplace, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi 1 (888) 560-2025.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Molina's toll-free telephone number for information or to make a complaint at:

1-888-560-2025 or

1-800-735-2989 TTY

You may also write to Molina at:

Member Complaints & Appeals
P.O. Box 165089
Irving, TX 75038

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Molina's para obtener información o para presentar una queja al:

1-888-560-2025 or

1-800-735-2989 TTY

Usted también puede escribir a Molina:

Member Complaints & Appeals
P.O. Box 165089
Irving, TX 75038

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañias, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañia primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos de informativos y no se convierte en parte o en condición del documento adjunto.

TABLE OF CONTENTS

AGREEMENT

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

This Agreement, riders, amendments to this Agreement, the applicable Schedule of Benefits for this product and any application(s) submitted to Molina and/or the Marketplace to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the legally binding contract between Molina and the Subscriber. Any change to this Agreement must be approved by an officer of Molina Healthcare and attached to this Agreement, and no agent has the authority to change the Agreement or waive any of its provisions.

WELCOME

Welcome to Molina Healthcare!

Here at Molina, We will help You meet Your medical needs. If You are a Molina Member, this EOC tells You what services You can get.

Molina Healthcare is a Texas licensed Health Maintenance Organization.

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

Molina Healthcare of Texas, Inc.
Customer Support Center
5605 MacArthur Blvd, Suite 1200
Irving, TX 75038
1 (888) 560-2025
www.MolinaMarketplace.com

If You are deaf or hard of hearing You may contact Us through Our dedicated TTY line, toll-free, at 1 (800) 735-2989 or by dialing 711 for the Telecommunications Service.

INTRODUCTION

Thank You for choosing Molina Healthcare as Your health plan.

This document is called Your "Molina Healthcare of Texas, Inc. Agreement and Individual Evidence of Coverage" (Your "Agreement" or "EOC"). The EOC tells You how You can get services through Molina. It also sets out the terms and conditions of coverage under this Agreement. It tells You Your rights and responsibilities as a Molina Member. It explains how to contact Molina. Please read this EOC completely and carefully. Keep it in a safe place where You can get to it quickly. There are sections for special health care needs.

You have 10 days to examine this Agreement. Return it to us if You are not satisfied for any reason. We will refund premiums paid to You upon return of the Agreement. The Agreement will be considered void from the beginning. If any Covered Services have been rendered or claims paid by Molina Healthcare during the 10 days, You will be responsible for repaying Molina Healthcare for the services or claims.

Molina Healthcare is here to serve You.

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

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

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

Call Us toll-free at 1 (888) 560-2025 between 8:00 a.m. to 6:00 p.m. CT. We are here Monday through Friday. If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line toll-free at 1 (800) 735-2989. You can also dial 711 for the Telecommunications 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 Healthcare uses and shares Your information to provide You with health benefits. Molina Healthcare wants to let You know how Your information is used or shared.

Your Protected Health Information

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

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

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

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

Molina Healthcare needs Your written approval to use or share Your PHI for uses not listed above.

What are Your privacy rights?

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

How does Molina Healthcare protect Your PHI?

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

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

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. **Our Notice of Privacy Practices is in the following section of this EOC. It is on Our web site at www.MolinaMarketplace.com. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center. The number is 1-888-560-2025.**

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF TEXAS, 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 Texas, Inc. ("**Molina Healthcare**", "**Molina**", "**We**" or "**Our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment, payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2014.

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

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

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

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

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

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

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Address 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 Healthcare use or share Your PHI without getting written authorization (approval) from You?
The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes. These include 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 Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave 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 ask us not to share Your PHI with family, friends, or other persons You name who are involved in Your health care. However, We are not required to agree to Your request. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give You Your PHI in a certain way or at a certain place to help keep it private. We will follow reasonable requests if You tell us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by us. This may include records used in making coverage, claims, and other decisions as a Molina Healthcare Member. You will need to make Your request in writing. You may use Molina's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases, We may deny the request.
  Important Note: We do not have complete copies of Your medical records. If you want to look at, get a copy of, or change Your medical records, please contact Your doctor or clinic.

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

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that We give You a list of certain parties that We shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:
    -
    - For treatment, payment or health care operations;
    - To persons about their own PHI;
    - Shared 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 Healthcare's form to make Your request.
You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Our Customer Support Center at 1-888-560-2025.

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

You may complain to us at:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P.O. Box 165089
Irving, TX 75038

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
1301 Young Street, Suite 1169
Dallas, TX 75202

What are the duties of Molina Healthcare?
Molina Healthcare is required to:

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

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this Notice at any time. If We do, the new terms and practices will then apply to all PHI We keep. If We make any material changes, Molina will post the revised Notice on Our web site and send the revised Notice or information about the material change and how to obtain the revised Notice, in Our next annual mailing to Our members then covered by Molina.

Contact Information

If You have any questions, please contact the following office:

Customer Support Center
5605 MacArthur Blvd, Suite 400
Irving, TX 75038
Phone: 1-888-560-2025

HELP FOR NON-ENGLISH SPEAKING MOLINA HEALTHCARE MEMBERS

Interpreter Services
As a Molina Healthcare Member, You have access to interpreter services. You have access 24 hour a day, seven (7) days a week.
You do not need to have a minor, friend, or family member act as Your interpreter. You may wish to say things in private. Using an interpreter may be better for You. Please call the Customer Support Center toll-free at 1 (888) 560-2025**.**

How do You use the interpreter services?

- For Your doctor's office or clinic visits
- Labs, clinics, or other medical service offices
- The pharmacy where You get Your medicine
- The emergency room at a hospital

The office or pharmacy may have a staff person who speaks Your language. If they do not, they will call the Customer Support Center to arrange for interpreter services by phone. You will be able to discuss and get the information You need using the telephone interpreter.

Call us if You have any questions.
Customer Support Center toll-free at:
1 (888) 560-2025

You are deaf or hard of hearing You may contact us through Our dedicated TTY line. The toll-free number is 1 (800) 735-2989. You may also dial 711 for the National Relay Service.

You can get help to understand this information in Your language. Please call Molina Healthcare Customer Support at 1-(888) 560-2025.

DEFINITIONS

Some of the words used in this EOC do not have their usual meaning. Health plans use these words in a special way. When We use a word with a special meaning in only one section of this EOC, We explain what it means in that section. Words with special meaning used in any section of this EOC are explained in this "Definitions" section.

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

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

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

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

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

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

"**Benefits and Coverage**" (also referred to as "Covered Services") means the healthcare services that You are entitled to receive from Molina under this Agreement.

"Child-Only Coverage" means coverage under this EOC that is obtained by a responsible adult to provide benefit coverage only to a child under the age of 21.

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

"**Cost Sharing**" is the Copayment that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Texas, Inc. Schedule of Benefits.

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in this EOC.

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

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

"**Emergency**" or "**Emergency Medical Condition"** means the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity. Including severe pain, which the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person; or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"**Emergency Services**" health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- Place the individual's health in serious jeopardy;
- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part;
- Result in serious disfigurement; or
- For a pregnant woman, result in serious jeopardy to the health of the fetus.

"**Essential Health Benefits**" or "EHB" means a standardized set of essential health benefits that are required to be offered by Molina Healthcare to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance
- use disorder services. This includes behavioral health treatment
- Prescription drugs
- Rehabilitative and Habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including dental***** and vision care for Members under the age of 19

*****Pediatric dental services are not covered under this EOC. These dental services can be separately provided through a stand-alone dental plan that is certified by the Marketplace.

"**Experimental or Investigational**" means any medical service including treatment, procedures, equipment, medications, facilities, and devices not accepted as standard medical treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time the services are provided, including, in the case of a drug, in the dosage to be used for the patient.

have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
are appropriate for the hospital or other provider in which they were/will be performed; and
the Participating Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of Molina Healthcare will determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental or Investigational within this definition, and will consider the guidelines and practices of Medicare, Medicaid or other government-financed programs in making its determination. Although a physician may have prescribed the treatment, and the services or supplies may have been provided as the treatment of last resort, Molina Healthcare may still determine that such services or supplies are Experimental or Investigational within this definition. Treatment provided as part of a clinical trial or research study is Experimental or Investigational.

"**FDA**" means the United States Food and Drug Administration.

"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 Texas buy qualified health plan coverage from insurance companies or health plans such as Molina Healthcare. The Marketplace may be run as a state-based marketplace, a federally facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State of Texas, however; it may be organized and run.

"**Medically Necessary"** or "**Medical Necessity**" means health care services determined by a provider, in consultation with Molina Healthcare, to be clinically appropriate or clinically significant, in terms of type, frequency, event, site, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by Molina Healthcare consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

"**Member**" (also referred to as "You" or "Your") means an individual who is eligible and enrolled under this Agreement, and for whom We have received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is not applying for coverage on their own behalf, but is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a minor child who, as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this product but will not be a Member. Throughout this EOC, "You" and "Your" may be used to refer to a Member or Subscriber, as the context requires.

"**Molina Healthcare of Texas, Inc. (also** referred to as **"Molina Healthcare" or "Molina", "We", or "Our" or "Us")**" means the corporation licensed in the state of Texas as a Health Maintenance Organization, and contracted with the Marketplace.

"**Molina Healthcare of Texas Agreement and Individual Evidence of Coverage**" (also referred to as "Agreement" or "EOC") means this document, 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 Primary Care Physicians or Specialist Physicians.

"**Participating Provider**" refers to those providers, including hospitals and physicians, which have entered into contracts with Molina 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 referred to as 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.
- Obstetrician and Gynecologist

"**Primary Care Provider**" or "**PCP**" means:

- a Primary Care Doctor, or
- an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor, or
- and Other Practitioner who within the scope of his or her license is authorized to provide primary care services.

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

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

"**Referral**" means the process by which the Member's Primary Care Doctor directs the Member to seek and obtain Covered Services from other providers.

"**Service Area**" means the geographic area in Texas where Molina Healthcare has been authorized by the Texas 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 has entered into a contract and who has identified their primary professional designation to Us as other than a "PCP", to deliver Covered Services to Members.

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

includes the Subscriber's common law spouse if the Subscriber and spouse are a couple who meet all of the requirements of Texas law and are Texas registered common law spouses, or the Subscriber's domestic partner in a domestic partnership registered with the Texas County Clerk.

"**Subscriber**" means either:

- An individual who is a resident of Texas, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina in accord with the terms of this Agreement; or
- A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 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 Services" means: means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

"Telemedicine Services" means: a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

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

ELIGIBILITY AND ENROLLMENT

When Will My Molina Membership Begin?

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

For coverage during the plan 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. You must be eligible under the special enrollment procedures established by the Marketplace and/or Molina and your reason for eligibility must be verified with documentation that is acceptable to the Marketplace and/or Molina. In such case, the Effective Date of coverage will be determined by the Marketplace. The Marketplace and/or Molina will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

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

Who is Eligible?

To enroll and stay enrolled You must meet all of the eligibility requirements. These are set by the Marketplace. Check the Marketplace's website at [healthcare.gov] for these requirements. Molina requires that the Subscriber lives, resides, or works in the service to be enrolled in the product. You will be 100% responsible for payment to Non-Participating Providers and the payments will not apply to the Out-of-Pocket Maximum with the exception of the services below:

- Emergency Services
- Medically Necessary Prior Authorized services
- If medically necessary covered services are not available through in-network physicians or providers, Molina will upon the request of an in-network physician or provider:
    a. Allow Referral to a non-network physician or provider; Fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate

Before denying a request for a Referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the Referral is requested.

For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. Molina requires Members to live in Molina's Service Area for this EOC. If You have lost Your eligibility, You may not be able to re-enroll. This is described in the section titled "When Will My Molina Membership End? (Termination of Benefits and Coverage)."

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

Dependents: Subscribers who enroll during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents. This is established by the Marketplace. Dependents must meet the eligibility requirements. Dependents must live in Our Service Area for this product with the exception of any Dependent child, unless required by state or federal regulations. The following family members are considered Dependents:

- **Spouse**
- **Children**: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren) and any child for whom the Subscriber must provide medical support by a medical support order. Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- **Subscriber's grandchildren** qualify as Dependents of the Subscriber only if the grandchild is unmarried, younger than 25 years of age and a dependent of the Subscriber for federal income tax purposes at the time application for coverage is made. Once enrolled coverage for a grandchild of the Subscriber will not be terminated solely because the grandchild is no longer a dependent of the Subscriber for federal income tax purposes.

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

The child is incapable of self-sustaining employment due to mental retardation or physical handicap.
The child is chiefly dependent upon the Subscriber for support and maintenance.

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

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after You as the Subscriber are enrolled (such as a new Spouse, a newborn child, newly adopted child, Foster Child, or a child only dependent), You must contact the Marketplace and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to the Marketplace within 60 days from the date the Dependent became eligible to enroll with Molina Healthcare.

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

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

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

Children Under 26 Years of Age: You can add a Dependent under the age of 26, including a stepchild, , except in Child-Only Coverage. You must apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

- The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act.
- The child becomes a Dependent through marriage, birth, placement in foster care, adoption, placement for adoption, child support, or other court order(a child covered through a court order and who lives outside of the service area will receive the same benefits).
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.

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 (including the date of birth).

Please note: claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's 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 Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Annual Out-of-Pocket Maximum (i.e. not under the enrolled mother's 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 date the child has become the subject for a suit for adoption or placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier. The child's coverage shall be effective on the date of the child has become the subject for a suit for adoption or placement for adoption or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.the date the child has become the subject for a suit for adoption or placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier.

Foster Child: A newly foster child or child placed with You or Your Spouse for foster care is covered from whichever date is earlier:

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

If You do not enroll the foster child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days. This includes the date of placement in foster care or when the legal right to control the child's health care was gained, whichever is earlier. For purpose of this requirement, "legal right to control health care" means You or Your Spouse have:

- A signed written document. This can be:
    - A health facility minor release report
    - A medical authorization form, or
    - A relinquishment form) or
- Other evidence that shows You or Your Spouse has the legal right to control the child's health care.

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

Discontinuation of Dependent Benefits and Coverage: Benefits and Coverage for Your Dependent will be discontinued on:

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

If You are no longer eligible for this product, We will send You a letter letting You know at least 10 days before the effective date on which You will lose eligibility. At that time, You can appeal the decision.

MEMBER IDENTIFICATION CARD

You get a Member identification card (ID card) from Molina Healthcare. We will issue an ID card within 10 business days after You make your first payment. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, you can get a temporary ID card at MyMolina.com, and you can request a new ID card at MyMolina.com or by calling Molina Healthcare toll-free at 1 (888) 560-2025. We will be happy to send You a new ID card.

If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-2025.

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

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- Molina Healthcare's 24 hours Nurse Advice Line toll-free number [1 (888) 275-8750].
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription related questions CVS Caremark Pharmacy Help Desk : 1 (800) 364-6331
- Toll free number for emergency rooms to notify Molina Healthcare of emergency room admissions for Our Members Emergencies (24 hrs.): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
- If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1-888-560-2025.

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

ACCESSING CARE

How Do I Get Medical Services Through Molina Healthcare?
(Choice of Doctors and Providers; Facilities)
PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHO OR WHAT GROUP OF PROVIDERS' HEALTH CARE SERVICES MAY BE OBTAINED.

Except for the following exceptions, You must receive Covered 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 Out-of-Pocket Maximum.

- Emergency Services
- Medically Necessary Prior Authorized services

- If medically necessary covered services are not available through in-network physicians or providers, Molina will upon the request of an in-network physician or provider:
  a. Allow Referral to a non-network physician or provider;
  b. Fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

Before denying a request for a Referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the Referral is requested.

Molina Healthcare, a health maintenance organization (HMO) plan provides no benefits for services You receive from out-of-network providers, with specific exceptions as described in Your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers). If You believe that the network is inadequate, You may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

If Molina approves a Referral for out-of-network services because no network physician or provider is available, or if You have received out-of-network emergency care, Molina must, in most cases, resolve the out-of-network physician's or provider's bill so that You only have to pay any applicable in-network copayment amount.

You may obtain a current directory of network physicians and providers at the following website: Molinahealthcare.com or by calling 1-888-560-2025 for assistance in finding available network physicians and providers. If You relied on materially inaccurate directory information, You may be entitled to have a claim by an out-of- network physician or provider paid as if it were from a network physician or provider, if You present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

Your Provider Directory includes a list of the Primary Care Providers and hospitals that are available to You as a Member of Molina Healthcare. You may visit Molina's website at **MolinaMarketplace.com** to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy. If You believe that the network is inadequate, You may file a complaint with the Texas Department of Insurance at : www.tdi.texas.gov/consumer/complfrm.html

The first person You should call for any health care is Your Primary Care Provider.

If You need hospital or similar services, You must go to a Health Care Facility that is a Participating Provider. For more information about which facilities are with Molina or where they are located, call Molina toll-free at 1 (888) 560-2025. 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 Annual Out-of-Pocket Maximum. However, You may receive services from a Non-Participating Provider:

1. for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services", and
2. 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. Telehealth and telemedicine services will be provided to the same extent that Covered Services are provided for the service or procedure in an in-person setting. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email only
- Member cost sharing is shown in Your Schedule of Benefits

Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment. Please refer to the "Definition" section for explanation.

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

ALWAYS CONSULT YOUR PRIMARY CARE PROVIDER FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALIST 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 Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.

ALWAYS CONSULT YOUR PRIMARY CARE PROVIDER FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALIST OR OTHER PRACTITIONER CARE.	
Type of help You need:	Where to go. Whom to Call.
Urgent Care Services	Call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537 for directions.
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 Healthcare's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation	Go to a qualified mental health Participating Mental Health or Substance Abuse Provider. You do not need a referral or Prior Authorization to get a mental health or substance abuse evaluation.
For mental health or substance abuse therapy	For mental health or substance abuse therapy, You do not need a referral or Prior Authorization from Your Participating Provider.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. If You need Emergency Services, refer to the Emergency Services section for details.
To have surgery	Go to Your PCP first. If You need Emergency Services, refer to the Emergency Services section for details.
To get a second opinion	Consult Molina's Provider Directory. You go to Our website at www.MolinaMarketplace.com to find a Participating Provider for a second opinion.
To go to the Hospital	Go to Your PCP first. If You need Emergency Services, get help as directed under Emergency Services above.
After-hours care	You can also call Molina Healthcare's Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537. You also have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free 1(888) 560-2025. If You are deaf or hard of hearing, You may contact Us by dialing [**7-1-1**] for the Telecommunications Relay Service.

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

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

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

If You want to know more about Your PCP or other Molina Healthcare doctors, call Us. Molina's Customer Support Center number is toll-free at 1 (888) 560-2025.

Choosing Your Doctor (Choice of Physician and Providers)
For Your health care to be covered under this product, Your health care services must be provided by Molina Healthcare Participating Providers. This includes doctors, hospitals, Specialist Physicians, Urgent Care clinics or medical clinics. The exception is Emergency Services or to an out-of-network Provider previously authorized by Molina Healthcare. For more information, please refer to the section of the Agreement titled "Emergency Services and Urgent Care Services". If Medically Necessary Covered Services are not available through a Participating Provider, upon prior authorization Molina Healthcare will allow a Referral to a non-Participating Provider, upon the request of Your Participating Provider and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member, but in no event to exceed five business days after receipt of reasonably requested documentation. Molina will fully reimburse the non-Participating Provider at the usual and customary rate or at an agreed rate. Any such request will be reviewed by a Specialist Physician of the same specialty as the provider to whom a Referral is requested.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and hospitals that are available under Molina Healthcare's health plan. You will also learn some helpful tips on how to use Molina Healthcare's services and benefits. Visit Molina Healthcare's website at www.MolinaMarketplace.com to view Our online list of providers, or call Molina Healthcare toll-free at 1 (888) 560-2025 to receive a printed copy. A map showing the Molina Healthcare service area is also available at the back of this EOC and on Our website.

You can find the following in Molina's Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Professional qualifications (e.g. board certification)
- You can also find out if a Participating Provider is taking new patients. This includes doctors, hospitals, specialist physicians, or medical clinics.
- You can also find out if a Participating Provider, including doctors, hospitals, specialist physicians, or medical clinics, is accepting new patients in Your Provider Directory.

Note: Some hospitals and providers may not provide some of the services that may be covered under this EOC that You or Your family member might need. This may include family planning,

birth control, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery). 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) 560-2025 to make sure that You can get the health care services that You need.

How Do I Choose a Primary Care Provider (PCP)?
It's easy to choose a Primary Care Provider (or PCP). Simply use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family or You may want to choose one doctor for You and another one for Your family members. If You have a chronic, disabling, or life-threatening illness, You may want to ask Molina Healthcare to allow You to use a non-primary care Specialist Physician as Your PCP. Contact Our Customer Support Center toll-free at 1 (888) 560-2025 to obtain the form to submit to Molina Healthcare. Molina Healthcare will approve or deny Your request within 30 days after receiving the written request. If the request is denied, You may appeal the denial through Molina Healthcare's complaint and appeal process.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You choose a PCP that You feel comfortable with. If You are female, You may, but are not required to, choose an OB/GYN (woman's doctor) to be Your PCP, and You may choose a pediatrician to be Your children's PCP.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina Healthcare toll-free at 1 (888) 560-2025. Molina Healthcare 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 doctor.

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

CHANGING YOUR DOCTOR

What if I Want to Change my Primary Care Provider?
You can change Your PCP at any time. All changes you make will become effective the next business day after notice to Molina.. Before you request a PCP change, if possible, first visit Your new PCP. Get to know Your PCP before changing. A good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina PCP.

Can my Primary Care Provider request that I change to a different Primary Care Provider?
Your Primary Care Provider may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor-patient relationship breakdown

How do I Change my Primary Care Provider?
Call Molina Healthcare toll-free at 1 (888) 560-2025. We are here Monday through Friday, 8:00 a.m. to 6:00 p.m. CT. You may also visit Molina's website at www.MolinaMarketplace.com to view Our online list of doctors. Let Us help You make the change.

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

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

What if my doctor or hospital is not with Molina?

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

If You are assigned to a PCP or hospital that is ending a contract with Molina Healthcare, then Molina Healthcare will provide You written notice of such a contract ending between Molina Healthcare and PCP or acute care hospital.

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 until the 90th day after the effective date of the termination, whichever is shorter.. Your doctor must also agree not to charge You for any amount that You would not have been responsible for paying if the provider had remained in the Molina Healthcare network. The treating Participating Provider must request that You be permitted to continue treatment under their care.

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

An "Active Course of Treatment" is:

1) an ongoing course of treatment for a Life-Threatening Condition;
2) an ongoing course of treatment for a Serious Acute Condition;
3) an ongoing course of treatment for a Special Circumstance;
4) the 24th week of pregnancy, through the postpartum period and a follow-up checkup within the six-week period after delivery; or
5) 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, for example chemotherapy, post-operative visits, or radiation therapy.

A "special circumstance" is

- a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy.

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 up to nine-months after effective date of termination, if you were diagnosed with a terminal illness, at the time of your Provider's participation with Molina ends
- upon completion of the 90th day of continuity of care
- if care is not Medically Necessary
- if you become ineligible for coverage

If you have a dispute regarding the necessity for continued treatment by a physician or provider You can follow the complaint process in the "Complaints and Appeals" section.

Transition of Care

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

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

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

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

   For Inpatient 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?

In the event Medically Necessary Covered Services are not reasonably available through Participating Providers, You may request Prior Authorization review to determine whether obtaining Covered Services from a Non-Participating Provider would be warranted by Medical Necessity review for the specifically requested medical condition.

If Covered Services are not reasonably available by Participating Providers, Molina will evaluate the Medical Necessity of such services requested by Your PCP, Specialist or Other Practitioner, and if warranted provide access to Non-Participating Providers as Covered Services for the specifically requested medical condition . Molina will pay the Non-Participating Provider at the usual and customary rate or at an agreed rate. You will only be responsible for the Copayment amount shown in the Schedule of Benefits.

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 refer to the Continuity of Care section of this document for full details.

If You receive a bill, other than for your Cost Sharing as shown in the Schedule of Benefits, from your provider (balance bill), You should contact Molina's Member Services department at the phone number on Your ID card

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 Service. Call by dialing 711. Registered Nurses staff the Nurse Advice Line. They are open 24 hours a day, 365 days a year.

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

Urgent care for Covered Services	Within 24 hours of the request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request
Routine or non-urgent care	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care
Non-urgent care with a non-physician. Behavioral health care provider	Within two weeks of the appointment request
Urgent care for Covered Services	Within 24 hours of the request
Routine or non-urgent care	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care

PRIOR AUTHORIZATION

What is a Prior Authorization?
A Prior Authorization is an approval by Molina that confirms that a requested health care service, treatment plan, prescription drug or item of durable medical equipment has been determined to be Medically Necessary and is covered under Your plan. A prior authorization is not a guarantee of claim payment. 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:

- Certain Sleep studies (home based)
- Emergency Services
- Family planning services
- Hospice inpatient care (notification only)
- Human Immunodeficiency Virus (HIV) testing & counseling
- The following 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
  - Pregnancy and delivery (notification only; Prior Authorization is not required; please notify Molina before services are rendered)
- Services for sexually transmitted diseases
- The following substance abuse services:
    - Individual and group substance abuse counseling
    - 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)
- Urgent Care Services from a Participating Provider

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

- Admission in a hospital or ambulatory care center for dental care.
- All inpatient admissions (except hospice)
- Ambulatory Surgery Center service (ASC)
- Certain Experimental and Investigational procedures (denials for experimental and investigational procedures are subject to review by an independent review organization (IRO))
- Certain Habilitative Services
- Certain Specialty pharmacy drugs (oral and injectable)
- Cosmetic, plastic and reconstructive procedures (in any setting)
- Custom orthotics, custom prosthetics, splints, and braces. Examples are:
    - Any kind of wheelchair
    - Implanted hearing device
    - Scooters
    - Shoes or shoe supports
    - Special braces
- Drug quantities that exceed the day-supply limit
- Durable Medical Equipment
- Gene therapy (Most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.)
- Experimental and Investigational procedures
- Home infusion therapy - After 7 visits for outpatient and 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
- Injectable drugs And medications not listed on the Molina Drug Formulary
- Low vision follow-up care
- Medically necessary genetic counseling and testing
- Mental Health Services
    - Day treatment
    - Electroconvulsive Therapy (ECT)

    - Mental health inpatient
    - Neuropsychological and psychological testing
    - Partial hospitalization
    - Behavioral health treatment for PDD/autism
- Out-of-network Urgent Care services
- Outpatient hospital service
- Pain management care and procedures, except trigger point injections
- Radiation therapy and radio surgery Rehabilitative services
- Services Rendered by a Non-Participating Provider
- Sleep studies (except home sleep studies)
- Substance Abuse Services:
    - Inpatient services
    - Day Treatment
    - Detoxification Services
    - Partial hospitalization
- Surgery or other procedures to correct diagnosed infertility. This is subject to "Exclusions" from coverage.
- Transplant evaluation and related service including Solid Organ and Bone Marrow (Cornea transplant does not require authorization)
- Transportation (Non-Emergency Air Ambulance)
- Unlisted and miscellaneous medical codes or any other services listed as needing Prior Authorization in this EOC.

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

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

Approvals are given based on Medical Necessity. We are here to help you, if You have questions about how a certain service is approved, call us. The number is 1 (888) 560-2025 If You are deaf or hard of hearing, call Our TTY line. That number is toll-free at 1 (800) 735-2989 or dial 711 for the Telecommunications Service.

We will be happy to send You a general explanation of how certain Prior Authorization decisions are made. You can also visit us at Molinamarketplace.com for information on our Prior Authorization.

You may call Molina Healthcare at 1 (888) 560-2025 to request Prior Authorization. Routine Prior Authorization requests will be processed within three calendar days from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination. Medical conditions that may cause a serious threat to Your health and requests when the Member is an inpatient are processed within 24 hours. This is 24 hours from when we get the information we need and ask for. We need this information to make the decision. We will deny a Prior Authorization if information We request is not provided to Us. The time required may be shorter under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. In the case of a request for preauthorization of post-stabilization treatment or a request for preauthorization involving life-threatening condition Molina will process the request within the time appropriate to the circumstances and the condition of the enrollee, up to one hour but in no case shall approval or denial exceed one hour from the time of the request.

If a service request is not Medically Necessary it may be denied. If it is not a Covered Service it may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are in the section "COMPLAINTS AND APPEALS" section.

Standing Approvals
You may have a condition or disease that requires special medical care over a long period of time. You may need a standing approval.

Your condition or disease may be life threatening. It may worsen. It could cause disability. If this is true You may need a standing approval to a specialist physician. You may need one for a specialty care center. They have the expertise to treat Your condition.

To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina's doctors and specialist physicians to be sure Your treatment plan meets Your medical needs. If You have trouble getting a standing approval, call Us. The number is toll-free 1(888) 560-2025. For deaf or hard of hearing call Our dedicated TTY line. That toll-free at 1 (800) 735-2989 or dial 711 for the Telecommunications Service.

Molina will review an existing prior authorization received 60 days before the expiration of the existing preauthorization and issue a determination indicating whether the medical or health care service is preauthorized.

If You feel Your needs have not been met please see Molina's grievance process These instructions are in the section "COMPLAINTS AND APPEALS" starting on

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

Here are some reasons why You may get a second opinion:

- Your symptoms are complex or confusing.
- Your doctor is not sure the diagnosis is correct.
- You have followed the doctor's plan of care and Your health has not improved.
- You are not sure if You need surgery.
- You do not agree with what Your doctor thinks is Your problem.
- You do not agree with Your doctor's plan of care.
- Your doctor has not answered Your concerns about Your diagnosis or plan of care.
- There may be other reasons. Call Us if You have questions.

EMERGENCY SERVICES AND URGENT CARE SERVICES

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

- A medical condition with acute and severe symptoms. This includes severe pain.
- A psychiatric condition with acute and severe symptoms
- Active labor.
- For a pregnant woman, which results in serious jeopardy to the health of the fetus must be included

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

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

Emergency Services also includes Emergency contraceptive drug therapy, , this does not include abortifacients, and all other Emergency Care or Urgent Care services required by state or federal law which includes:

- a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;
- necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization.

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:

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

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

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

- English - 1 (888) 275-8750
- Spanish - 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 Service by dialing 711.

Please do not go to a hospital emergency room if Your condition is not an Emergency.

If You are away from Molina Healthcare's Service Area need Emergency Services?

Go to the nearest emergency room for care. Please contact Molina within 24 hours or as soon as You can. Call toll-free at 1 (888) 560-2025. If You are deaf or hard of hearing, call Our TTY line toll-free at 1 (800) 735-2989 or dial 711 for the Telecommunication Service. When You are away from Molina's Service Area only Emergency Services are covered.

What if I need after-hours care or Urgent Care Services?
Urgent Care Services are available from Participating Providers when You are within Molina's Service Area. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services call Your PCP or Molina's 24-Hour Nurse Advice Line. The number is toll-free.

- English 1 (888) 275-8750
- Spanish 1 (866) 648-3537

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

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

If You are outside of Molina's Service Area You may go to the nearest emergency room.

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Please be aware that You must get services from a Participating Provider

You have the right to interpreter services at no cost. To help in getting after hours care call toll-free at 1 (888) 560-2025.

Emergency Services Rendered by a Non-Participating Provider

Emergency Services for treatment of an Emergency Medical condition are subject to cost sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Schedule of Benefits
Molina will approve or deny coverage of post-stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

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

1) Molina's usual and customary rate for such services, or
2) An agreed upon rate for such services

You will only be responsible for the Copayment or other Out-of-Pocket amounts that You would have paid had Molina's provider network included network physicians or providers from whom You could have obtained these services. Please see the Schedule of Benefits for Your Copayment and Out-of- Pocket amounts for specific services.

COMPLEX CASE MANAGEMENT

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

The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems. The nurse can teach You how to manage them. The nurse may also work with Your family or caregiver to make sure You get the care You need. The nurse also works with Your doctor. There are several ways You can be referred for this program. There are certain requirements that You must meet. This program is voluntary. You can choose to be removed from the program at any time.

If You would like information about this program, please call the Customer Support Center toll free. The number is 1 (888) 560-2025. Deaf or hard of hearing members can call Our dedicated TTY line toll-free at 1 (800) 735-2989 or dial 711 for the Telecommunications Service.

PREGNANCY

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

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

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

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

If You need help choosing an OB/GYN, call Us. If You have any questions, call Molina toll-free at 1 (888) 560-2025, Monday through Friday from 8:00 a.m. to 6:00 p.m. CT. We will be happy to help You. Molina offers a special program called Motherhood Matters. This program provides important information about diet, exercise and other topics about pregnancy. For more information, call the Motherhood Matters pregnancy program. The toll-free number is 1 (877) 665-4628. We are here Monday through Friday, between 10:30 a.m. and 7:30 p.m. (CDT).

ACCESS TO CARE FOR MEMBERS WITH DISABILITIES

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

Physical Access
Molina Healthcare has made every effort to ensure that Our offices and the offices of Molina Healthcare doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Molina Healthcare toll-free at 1 (888) 560-2025 or call Our dedicated TTY line toll-free at 1 (800) 735-2989 and a Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing
Let us know if You need a sign language interpreter at the time You make Your appointment. Molina Healthcare requests at least 72 hours advance notice to arrange for services with a qualified interpreter. Call Molina Healthcare's Customer Support Center through Our TTY Number toll-free at 1 (800) 735-2989, or dial 711 to use the National Relay Service.

Access for Persons with Low Vision or who are Blind
This EOC and other important plan materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available and this EOC is available in an audio format. For accessible formats, or for direct help in reading the EOC and other materials, please call Molina Healthcare toll-free at 1 (888) 560-2025. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Molina Healthcare's Customer Support Center.

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

COVERED SERVICES

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

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

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

COST SHARING (MONEY YOU WILL HAVE TO PAY TO GET COVERED SERVICES)
Cost Sharing is the Copayment, or Percentage Cost Sharing that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Texas, Inc. Schedule of Benefits.

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

You should review the MOLINA HEALTHCARE OF TEXAS, INC. SCHEDULEOF BENEFITS carefully. You need to understand what Your cost sharing will be.

Annual Out-of-Pocket Maximum

Also referred to as **"OOPM,"** this is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a plan year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Copayments.Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

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

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

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

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

Copayment
Copayment is a percentage of the charges for Covered Services, or a specific dollar amount, You must pay when You receive Covered Services. The Copayment amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider, or a specific dollar amount. Copayments are listed in the Molina Healthcare of Texas, Inc. Schedule of Benefits. Some Covered Services do not have Copayment.

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

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

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this EOC, You pay the Cost Sharing in effect on Your admission date. You will pay this Cost Sharing until You are discharged. The services must be covered under Your prior health plan evidence of coverage. You must also have had no break in coverage. However, if the services are not covered under Your prior health plan evidence of coverage You pay the Cost Sharing in effect on the date You receive the Covered Services. In addition, if there has been a break in coverage, You pay the Cost Sharing in effect on the date You receive the Covered Services.
- For items ordered in advance, You pay the Cost Sharing in effect on the order date. Molina will not cover the item unless You still have coverage for it on the date You receive it. You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order. They must receive all of the information they need to fill the prescription before they process the order.

Receiving a Bill
In most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. This payment may cover only a portion of the total Cost Sharing for the Covered Services 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:
    1. for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services", and
    2. for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

If You receive a bill, other than for Your Cost Sharing as shown in the Schedule of Benefits, from your provider (balance bill), You should contact Molina's Member Services department at the phone number on Your ID card.

If Molina authorizes You to receive services from a Non-Participating Provider, you will only be responsible for Your Cost Sharing as shown in the Schedule of Benefits. If You receive a bill, other than for Your Cost Sharing from a Non-Participating Provider, for services You were authorized by Molina to receive, You should contact Molina's Member Services department at the phone number on Your ID card.

How Your Coverage Satisfies the Affordable Care Act
Your Covered Services include Essential Health Benefits as required by the Affordable Care Act. If non-EHB coverage is included in Your product, those Covered Services will be set out in this EOC as well.

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

The Affordable Care Act provides certain rules for Essential Health Benefits. These rules tell Molina how to administer certain benefits and Cost Sharing under this EOC. For example, under the Affordable Care Act, Molina is not allowed to set lifetime limits or annual limits on the dollar value of Essential Health Benefits provided under this EOC. When EHB preventive services are provided by a Participating Provider, You will not have to pay any Cost Sharing amounts. In addition, Molina must ensure that the Cost Sharing, which You pay for all Essential Health Benefits, does not exceed an annual limit that is determined under the Affordable Care Act. For the purposes of this EHB annual limit, Cost Sharing refers to any costs, which a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable
For qualifying Subscribers, there may be assistance to help make the product that You are purchasing under this Agreement more affordable. If You have not done so already, please contact the Marketplace to determine if You are eligible for tax credits. Tax credits may reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits. The Marketplace also will have information

about any annual limits on Cost Sharing towards Your Essential Health Benefits. The Marketplace can assist You in determining whether You are a qualifying Indian who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina will work with the Marketplace in helping You.

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

What is Covered Under My Plan?
This section tells You what medical services Molina covers These are called Your Covered Services. Except for preventive care and services, for a service to be covered **it must be Medically Necessary**.

You have the right to appeal if a service is denied. These instructions are in the section "COMPLAINTS AND APPEALS".

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Turn to Experimental or Investigational Services for information. Molina also may cover routine medical costs for Members in Approved Clinical Trials.
Certain medical services described in this section will only be covered by Molina if You obtain Prior Authorization ***before*** seeking treatment for such services. To read more about Prior Authorization and a complete list of Covered Services, which require Prior Authorization, turn to "What is a Prior Authorization?" Prior Authorization does not apply to treatment of Emergency Conditions or for Participating Provider Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

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

- Those evidenced-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
- Those immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, those evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- Scheduled prenatal care exams and first postpartum follow-up consultation exam.

All preventive care must be furnished by a Participating Provider to be covered under this Agreement. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider unless Medically Necessary Prior Authorized service or Emergency Services.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement. Coverage will start for product

years, which begin one year after the date the recommendation or guideline is issued, or on such other date as required by the Affordable Care Act. The product year is based on the calendar year.

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

Preventive Services for Children and Adolescents
The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay Cost Sharing if services are furnished by a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider, unless Medically Necessary Prior Authorized service or Emergency Services.

- Administration of a newborn screening test screening
- Alcohol and Drug Use assessments for adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Autism screening for children 18-24 months
- Basic vision screening (non- refractive)
- Behavioral health assessment for children
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Cervical dysplasia screening: sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21.These include those with special health care needs.)
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Hearing screening (which includes hearing screening test from birth through the date the child is 30 days of age, refer to section " Hearing Services" for additional benefits where cost share may apply)
- Health management
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*****
- Iron supplementation in children when prescribed by a Participating Provider
- Lead blood level testing (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow-up and

get the blood test results. Contact Your PCP for additional questions.)
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Newborn screening test, including the cost of a test kit
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Sickle cell trait screening, when appropriate
- Tuberculosis (TB) screening
- Well baby /child care

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

Preventive Services for Adults and Seniors
The following outpatient preventive care services are covered and recommended for all adults, including seniors. You will not pay any Cost Sharing if You receive services from a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider, unless Medically Necessary Prior Authorized service or Emergency Services.

- 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)
- Annual Low-dose Mammograms, including breast tomosynthesis for women age 35 and over which must be performed at designated approved imaging facilities. Age limit does not apply to diagnostic screenings. Diagnostic screenings are to establish presence/absence of disease.
- Bacteriuria screening: pregnant women
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure check
- BRCA counseling about breast cancer preventive medication
- Breast cancer and chemoprevention counseling for women at high risk
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies counseling
- CA 125 blood test for screening of ovarian cancer for women 18 years and older Cancer screening
- Chlamydial infection screening: women
- Cholesterol check
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cytological Screening (pap smear) in a hospital or certified lab for the presence of cervical cancer
- Depression screening: adults
- Depression screening: Postpartum women

- Diabetes education and self-management training provided on the written order of a physician or other health care practitioner by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diet counseling: adults at higher risk for chronic disease
- Dietary evaluation and nutritional counseling
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Hearing screenings
- Health management and chronic disease management
- Healthy diet counseling
- Hepatitis B screening: pregnant women
- Hepatitis C screening for adults
- High blood pressure screening
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations
- Medical history and physical exam
- Obesity screening and counseling: adults
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
- One low-dose mammography annually for the presence of occult breast cancer for persons the age of 35 and over. Age limit does not apply to diagnostic screenings. Diagnostic screenings are to establish presence/absence of disease.
- Osteoporosis screening
- Prostate specific antigen testing
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection and pregnant women
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions
- Tuberculosis (TB) screening
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed)

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

PHYSICIAN SERVICES

We cover the following outpatient physician services:

- Audiology and hearing tests
- Consultations and well child care
- Diagnosis and medically indicated treatments for physical conditions causing infertility (Benefit covers only testing, diagnosis, and corrective procedure, subject to exclusions in the "Exclusions" section.)
- Injections, allergy tests and treatments
- Office visits (including pre- and post-natal visits)
- Osteoporosis services (including treatment and appropriate management when such service are determined to be Medically Necessary by the Member's PCP, in consultation with Molina)
- Outpatient maternity care (including complications of pregnancy and Medically Necessary at home care)
- Outpatient newborn care as described in "Newborn and Adopted Children Coverage" under this "What is Covered Under My Plan?" section
- Physician and other Practitioner care in or out of the hospital
- Prevention, diagnosis, and treatment of illness or injury
- Routine examinations and prenatal care provided by an OB/GYN to female Members. You may select an OB/GYN as Your PCP.
- Routine pediatric and adult health exams
- Specialist Physician consultations (for example, a heart doctor or cancer doctor)
- Telemedicine Visits
    - Visit must be medically necessary
    - Must be associated with an office visit
    - Electronic mail (e-mail) by a Practitioner/Provider or consultation by telephone for which a charge is made to the patient is not Covered
    - Visits to the doctor's office

Habilitative Services
We cover 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, habilitative autism benefit and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative Autism Benefit are excluded from the 35 visits per plan year limit.

Rehabilitative Services
We cover Medically Necessary rehabilitative services. These services help injured or disabled Members resume activities of daily living. This means services such as physical therapy, speech therapy, and occupational therapy. These would occur in the right setting for the level of disability or injury. Medically Necessary covered rehabilitative services will not be denied, limited, or terminated if the therapy or service meets or exceeds Your treatment goals. The services of a chiropractor must be in connection with outpatient rehabilitation, occupational therapy, and physical therapy.

OUTPATIENT MENTAL/BEHAVIORAL HEALTH SERVICES

We cover the following outpatient mental health services in the same terms and conditions as medical or surgical benefit expenses for any other physical illness when provided by Participating Providers who are physicians or Other Practitioners acting within the scope of their license and qualified to treat mental illness:

- Individual, family and group mental health evaluation and treatment

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

We cover outpatient mental or behavioral health services, including services for the treatment of gender dysphoria only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is identified in the most recent publication 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".

"**Mental Disorders**" include the following conditions:

Serious Mental Illness of a person of any age. ""Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- bipolar disorders (hypomanic, manic, depressive, and mixed);
- depression in childhood and adolescence;
- major depressive disorders (single episode or recurrent);
- obsessive-compulsive disorders;
- paranoid and other psychotic disorders;
- schizo-affective disorders (bipolar or depressive); and
- schizophrenia.

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) "Autism Spectrum Disorder" in the "Pediatric Services" section below.

OUTPATIENT AUTISM SPECTRUM DISORDER SERVICES

We cover treatment and services to Members who are diagnosed with autism spectrum disorder from the date of diagnosis Coverage is provided under this section to the Member for all generally recognized services prescribed in relation to autism spectrum disorder by the Member's primary care physician in the treatment plan recommended by that physician. An individual providing treatment must be:

(1) a health care practitioner;
   (a) who is licensed, certified or registered by an appropriate agency of the state;
   (b) whose professional credential is recognized and accepted by an appropriate agency of the United States; or
   (c) who is certified as a provider under the TRICARE military health system;
(2) an individual acting under the supervision of a qualified health care practitioner

Covered services include, but are not limited to:

- applied behavior analysis as defined in Texas insurance regulations;
- behavior training and behavior management;
- evaluation and assessment services;
- medications or nutritional supplements used to address symptoms of autism spectrum disorder;
- occupational therapy;
- physical therapy;
- screening at ages 18 months and 24 months; or
- speech therapy

The services must be provided by a Participating Provider or Other Practitioner who is licensed, certified, or registered by an appropriate agency of Texas. Their professional credentials must be recognized and accepted by an appropriate agency of the United States, or certified as a provider under the TRICARE military health system. All Covered Services are subject to the Cost Sharing requirements for Outpatient Professional Services.

All provisions of this Agreement will apply including, but not limited to, defined terms, limitations and exclusions, Prior Authorization and any applicable benefit maximums.

UTPATIENT SUBSTANCE ABUSE/CHEMICAL DEPENDENCY SERVICES

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

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

We cover substance abuse/chemical dependency under this EOC in the same terms and conditions as medical or surgical benefit expenses for any other physical illness. We do not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this Agreement.

DENTAL AND ORTHODONTIC SERVICES

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

Dental Services for Radiation Treatment

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

Dental Trauma

We cover services provided to correct damage to healthy, unrestored natural teeth and supportive tissues. These services will correct damage caused solely by external, violent accidental injury. An injury as the result of biting or chewing shall not be considered an accidental injury. This includes correction of a congenital effect and oral surgery which is defined as maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
- Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan; and
- Removal of complete bony impacted teeth.

Dental Anesthesia

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

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

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

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

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

PEDIATRIC DENTAL SERVICES
Pediatric dental services may be separately provided through a stand-alone dental plan that is certified by the Marketplace. Pediatric dental services are not covered under this product.

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, "Pediatric Vision Services."

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

- Routine vision screening and eye exam every plan year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months.
- Covered frames include a limited selection of frames. Participating Providers will show the limited selection of frames available to You under this product. Frames that are not within the limited selection of frames under this product are not covered.
- Prescription Lenses: include single vision, lined bifocal, lined trifocal, lenticular lenses and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.
- Fashion and gradient tinting, oversized and grey glasses #3 prescription sunglass lenses.
- Prescription Contact Lenses: limited to one pair every 12 months, in lieu of prescription lenses and frames; includes evaluation, fitting, and follow-up care. Also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of:
    - Aniridia
    - Aniseikonia

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

- Low vision optical devices are covered including low vision services training, and instruction to maximize remaining usable vision. Follow-up care is covered when services are Medically Necessary and Prior Authorization is obtained.
- With Prior Authorization, coverage includes:

  - one comprehensive low vision evaluation every 5 years;
  - high-power spectacles, magnifiers, and telescopes as Medically Necessary; and
  - follow-up care – four visits in any five-year period.

Laser corrective surgery is not covered.

Please refer to the Molina Healthcare of Texas, Inc. Schedule of Benefits for limitations and Cost Sharing

TREATMENT FOR ACQUIRED BRAIN INJURY

We cover treatment for Medically Necessary services for an Acquired Brain Injury on the same basis as treatment for other physical conditions. Cognitive rehabilitation and communication therapies, neurocognitive therapy and rehabilitation neurobehavioral, neuropsychological, neurophysiological and neuropsychological testing and treatment; neurofeedback therapy, remediation, post-acute transition and community integration services, including outpatient day treatment services, or any other post-acute treatment services are covered. Such services must be necessary as a result of and related to an Acquired Brain Injury. Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate treatment or therapies may be provided. Covered Services include reasonable expenses for periodic reevaluation of the care of a Member who has incurred an Acquired Brain Injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date. Treatment goals may include the maintenance of function or the prevention or slowing of deterioration.

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 FDA. As a Member, You pick a doctor who is located near You to receive the services You need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. You can do this without having to get Prior Authorization from Molina. (Molina pays the doctor or clinic for the family planning services You get.) Family planning services include:

- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's)
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Health management and counseling to help You make informed choices
- Health management and counseling to help You understand birth control methods

- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Limited history and physical examination.
- Pregnancy testing and counseling
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera
- Screening, testing and counseling of at-risk individuals for HIV, and Referral for treatment
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)

Coverage for certain Amino-Acid based elemental formulas
We cover Medically Necessary amino acid-based elemental formulas. This is regardless of the formula delivery system. They must be used for the diagnosis and treatment of:

1) immunoglobin E and non-immunoglobin E mediated allergies to multiple food proteins;
2) severe food protein-induced enterocolitis syndrome;
3) eosinophilic disorders, as evidenced by the results of a biopsy; and
4) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

The coverage includes any Medically Necessary services associated with the administration of the formula. It is subject to the written order of a Participating Provider. It must be for the treatment of a Member who is diagnosed with one of the above listed conditions. Coverage for formulas and special food products is provided on the same basis as any other prescription medication under this plan.

Phenylketonuria or other Heritable Diseases We cover testing and treatment of phenylketonuria (PKU). We also cover other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. Treatment of phenylketonuria or other heritable diseases will be to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.The health care professional will consult with a physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.

For purposes of this section, the following definitions apply:
"Formula" is an enteral product for use at home that is prescribed by a Participating Provider.

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

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

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient Surgery
We cover outpatient surgery services provided by Participating Providers. Services must be provided in an outpatient or ambulatory surgery center or in a hospital operating room. Separate Cost Sharing may apply for professional services and Health Care Facility services.

Outpatient Procedures (other than surgery)
We cover some outpatient procedures other than surgery provided by Participating Providers. A licensed

staff member must be required to monitor Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. These procedures include Medically Necessary endoscopic procedures. They also include the administration of injections and infusion therapy. Separate Cost Sharing may apply for professional services and Health Care Facility services for all outpatient procedures.

Specialized Scanning Services
We cover Medically Necessary specialized scanning services. They include CT Scan, PET Scan, cardiac imaging, and MRI by Participating Providers.

If You are diabetic or at risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher, Molina covers noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:

- computed tomography (CT) scanning measuring coronary artery calcification; or
- ultrasonography measuring carotid intima-media thickness and plaque

Separate Cost Sharing may apply for professional services and Health Care Facility services. Prior Authorization is required. Molina will help you select an appropriate facility.

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

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

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; treatment planning.

Laboratory Tests
We cover the following services when furnished by Participating Providers and Medically Necessary.; These services are subject to Cost Sharing:

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

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 Out-of-Pocket Maximum, Prior Authorized Medically Necessary service or Emergency Services are not subject to this requirement.

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

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

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services, except in the case of an Emergency services. If You get services in a Non-Participating Provider hospital or 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 to Non-Participating Providers, and the payments will not apply to the Annual Out-of-Pocket Maximum, unless Prior Authorized or Emergency Services.

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

- Anesthesia
- Biologicals, fluids and chemotherapy
- Drugs, medications and biologicals prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section)
- Durable Medical Equipment and medical supplies
- General and special nursing care
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Inhalation therapy
- Mastectomies (removal of breast) and lymph node dissections (not less than 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer)

- Mastectomy-related services, including Covered Services under the "Reconstructive Surgery" section and under the "Prosthetic and Orthotic Devices" section
- Medical social services and discharge planning
- Meals and special diets when medically necessary
- Operating and recovery rooms
- Oxygen services
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Private duty nursing when Medically Necessary
- Radioactive materials used for therapeutic purposes
- Respiratory therapy
- Room and board, including a private room if Medically Necessary
- Services of Participating Provider physicians, including consultation and treatment by specialist physicians
- Specialized care and critical care units
- Whole blood and blood, including the cost of blood, blood plasma, blood plasma expanders, and administration of whole blood and blood plasma
- Private Duty Nursing when medically necessary

Chemotherapy and other Providchemo therapy
er-administered Drugs
We cover chemotherapy when furnished by Participating Providers and Medically Necessary. Chemotherapy drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility cost sharing.

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; treatment planning.

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

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

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays require that You or Your provider notifies Molina. Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Molina Healthcare of Texas, Inc. Schedule of Benefits for the Cost Sharing that will apply to these services.
- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is shortened the timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that careHome care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory

Tests Cost Sharing will apply to laboratory services).
- If You are a medically high-risk pregnant woman about to deliver a baby, we cover transportation, including air transport, to the nearest appropriate Health Care Facility when necessary to protect the life of the infant or mother.

Mental/Behavioral Health
Inpatient Psychiatric Hospitalization
We cover inpatient psychiatric hospitalization in a Participating Provider hospital in the same terms and conditions as medical or surgical benefit expenses for any other physical illness. Coverage includes room and board, drugs, and services of Participating Provider physicians. It also covers other Participating Providers who are licensed health care professionals acting within the scope of their license. We cover inpatient hospital mental or behavioral health services, including services for the treatment of gender dysphoria only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

"**Mental Disorders**" include the following conditions:

- Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa

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) "Autism Spectrum Disorder" in the "Pediatric Services" section above.

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

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

We cover for substance abuse/chemical dependency under this EOC in the same terms and conditions as medical or surgical benefit expenses for any other physical illness.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY
TRANSITIONAL RESIDENTIAL RECOVERY SERVICES
We cover substance abuse treatment in a nonmedical transitional residential recovery setting approved in writing by Molina Healthcare. These settings provide counseling and support services in a structured environment.

We cover for substance abuse/chemical dependency under this EOC in the same terms and conditions as medical or surgical benefit expenses for any other physical illness.

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

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

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

The SNF benefit is limited to 60 days per plan year.

Hospice Care

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

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

The hospice benefit is for people who are diagnosed with a terminal illness. They can choose hospice care instead of the traditional services covered by this product. Please contact Molina for further information. You must receive Prior Authorization for all inpatient hospice care services.

Approved Clinical Trials
We cover routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition.

To qualify for such coverage You must:

- Be enrolled in this product
- Be diagnosed with life threatening disease or condition

- Be accepted into an approved clinical trial (as defined below)
- Be referred by a Molina doctor who is a Participating Provider
- Received Prior Authorization or approval from Molina
    - Such Prior Authorization or approval will be consistent with the standards in the Affordable Care Act

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 one of the following three statements is true:

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

- Agency for Health Care Research and Quality,
- The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- The Centers for Medicare & Medicaid Services
- The Department of Energy.
- The National Institutes of Health;
- The United States Food and Drug Administration;
- The United States Department of Defense;
- The United States Department of Veterans Affairs;
- An institutional review board of an institution in the state of Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services;
- Cooperative 1 group or center of any of (i) The National Institutes of Health, (ii) The Centers for Disease Control and Prevention, (iii) The Agency for Health Care Research and Quality, (iv) The Centers for Medicare & Medicaid Services, or the Department of Defense or the Department of Veterans Affairs; or,
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(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

All approvals and authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. Contact Molina or Your PCP for further information.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Your routine patient costs. Such costs are associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this EOC based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered. They will not be covered if the approved clinical trial is for the investigation of that drug. They will also not be covered for medication that is typically provided free of charge to Members in the clinical trial.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service was not specifically related to an approved clinical trial. In other words, You will pay the Cost

Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Texas, Inc. Schedule of Benefits.

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

RECONSTRUCTIVE SURGERY

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body. These abnormal structures may be caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. If a Participating Provider physician decides that it is necessary to improve function, or create a normal appearance, to the extent possible, the services will be covered.
- Following Medically Necessary removal of all or part of a breast, Molina covers reconstruction of the breast. Molina will also cover surgery and reconstruction of the other breast to produce a symmetrical appearance. Molina covers treatment of physical complications, including lymphedemas.
- For a child who is younger than 18 years of age Molina covers reconstructive surgery for craniofacial abnormalities. Such coverage includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

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 Molina Healthcare of Texas, Inc. Schedule of Benefits.

Reconstructive surgery exclusions

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

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

Transplant Services

We cover transplants of organs, tissue, or bone marrow at participating facilities. Molina must authorize services for care to a transplant facility, as described in the "Accessing Care" section, under "What is a Prior Authorization?".

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

- If either the physician or the authorized Health Care Facility determines that You do not

satisfy its respective criteria for a transplant, Molina will only cover services You receive before that decision is made.

- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor. Molina will provide services for an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You. This may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at 1 (888) 560-2025

For covered transplant services, You will pay the Cost Sharing You would pay if the Covered Services were not related to transplant services. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Texas, Inc. Schedule of Benefit. Limited transplant-related travel services will be covered subject to Prior Authorization.
Guidelines for transplant-related travel services are available by calling Our Customer Support Center toll- free at 1 (888) 560-2025.

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

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications when:

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

The prescription drug or medication must be filled through a pharmacy that is in the Molina pharmacy network.

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

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

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

All of Molina's contracted pharmacies have processes in place to allow You to pick up of all of Your ongoing prescription refills at the pharmacy on a single, convenient day each month. If less than a full refill is provided to You as a result of this process, You will only be charged for the amount of medication You receive.

Molina's pharmacy system will allow You to obtain refills for eye drops to treat chronic eye diseases and conditions at 21 day, 43 day and 63 day intervals.

Please note, Cost Sharing for any prescription brand name drugs with a generic equivalent obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third party cost-sharing assistance, will not apply toward 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 these types of drugs when they are on the Drug Formulary. We cover these types of drugs when obtained through Molina's Participating Provider pharmacies within the state of Texas 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 state of Texas (out of area) for Emergency Services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 560-2025 for assistance. If You are deaf or hard of hearing contact Us with the Telecommunications Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 560-2025. You may view a list of pharmacies on Molina Healthcare's website, www.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 will receive annual notices regarding prescription drug changes no later than 60 days prior to renewal.

Molina does not remove drugs from the Drug Formulary during the plan year. If drugs are discontinued Molina will notify You 30 days prior to the discontinuance of a concurrent prescription drug or intravenous infusion.

You can look at Our Drug Formulary on Our Molina Healthcare website. The address is www.MolinaMarketplace.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 560-2025. We are here Monday through Friday, 8:00 a.m. through 6:00 p.m. CT. If You are deaf or hard of hearing, call Our TTY line. The number is toll-free 1 (800) 735-2989. You may dial 711 for the Telecommunications Service.

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

Cost Sharing for Prescription Drugs and Medications

The Cost Sharing for prescription drugs and medications is listed on the Molina Healthcare of Texas, Inc. Schedule of Benefits. Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis. The exception is when such drug therapy is an EHB preventive care prescription drug administered or prescribed by a Participating Provider. In this case, the EHB preventive care prescription drug 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. Molina's negotiated rate is either the usual and customary amount or agreed rate.

Step Therapy and Considerations for Drugs that require a Prior Authorization

Our Pharmacy Director and/or Our Medical Director will review general medical criteria and will work in conjunction with your prescribing provider. The following parameters may be considered when reviewing Your request:

- diagnosis and relevant concurrent medical conditions,
- age, and sex,
- allergies,
- clinical rationale for selecting the drug,
- if Your condition being treated is consistent with FDA-approved indications and/or meets approved criteria for safe use,
- expected outcome of therapy and methods to be used to measure outcome,
- anticipated duration of therapy,
- previous experience with this drug, if any
- previous drug therapy, drug responses and adverse effects,
- concurrent drug therapy,
- compliance history,
- prescriber's familiarity with the drug,
- cost-effectiveness of the drug on overall healthcare costs, and
- whether or not the You have tried and failed an adequate supply of formulary drugs.

Does not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

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. The maximum Cost Share for an orally administered anti-cancer medication is for up to a 30 day supply. Please check your Schedule of Benefits for applicable Cost Share for an orally administered anti-cancer medication.

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 Preventive 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 may be required prior to receiving opioid analgesics for chronic pain, except under the following circumstances:

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

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

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

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

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

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

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

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

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

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

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

Step Therapy exception requests are considered an Expedited Appeal Request and the time frames described below apply

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

- 24 hours following receipt of request for Expedited Exception Request

- 72 hours following receipt of request for Standard Exception Request

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

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

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

Step Therapy Protocol and Exception Request
If initial request is not denied before 72 hours after We receive You and/or Your Participating Provider request, the request is considered granted.

If Your Participating Provider reasonably believes that denial of the request makes the death of or serious harm to You probable, the request is considered granted if We do not deny the request before 24 hours after receipt of the request. Your Participating Provider must make Us aware that Your Participating Provider reasonably believes that denial of the request makes the death of or serious harm to You probable.

Proration and Synchronization
Molina provides prescription drugs proration for a partial supply of a prescription drug if:

- the pharmacy or the enrollee's prescribing physician or health care provider notifies the health benefit plan that:
- the quantity dispensed is to synchronize the dates that the pharmacy dispenses the enrollee's prescription drugs; and
- the synchronization of the dates is in the best interest of the enrollee; and
- the enrollee agrees to the synchronization.

The proration described will be based on the number of days' supply of the drug actually dispensed.

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

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

Cost Sharing for Prescription Drugs and Medications

Stop-Smoking Drugs
We cover drugs to help You stop smoking. You will have no Cost Sharing for stop smoking drugs. You can also learn more about Your stop-smoking options by calling Molina Healthcare's Health Education Department toll-free at 1 (866) 472-9483, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-month supply of stop smoking medication.

Mail order availability of Formulary Prescription Drugs
Molina offers You a mail order pharmacy option on tiers 1, 2, 3, and 5. Formulary Prescriptions drugs can be mailed to You within 10 days from order request and approval. Cost Sharing up to a 90- day supply applied at two times Your appropriate Copayment based on Your drug tier for one month.

You may request mail order service in the following ways:

- You can order online. Visit www.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 www.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.

Orally Administered Anti-Cancer Medications
We cover Medically Necessary orally administered anti-cancer medications that are used to kill or slow the growth of cancerous cells. Specialty Oral and Injectable Drug Cost Sharing amounts apply to orally administered anti-cancer medications listed on the Molina Healthcare Drug Formulary.

Diabetes Supplies
Diabetes supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, glucagon emergency kits, blood glucose test strips, urine test strips, visual reading test strips, insulin analogs, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and injection aids are covered supplies. Which includes new or improved diabetic equipment and supplies, including improved insulin or another prescription drug approved by the United States Food and Drug Administration. 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.

ANCILLARY SERVICES

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

Covered DME includes (but is not limited to):

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

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

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

Prosthetic and Orthotic Devices
We do not cover most prosthetic and orthotic devices, but covered benefits will be provided in a manner determined to be appropriate in consultation with Your treating physician or podiatrist and prosthetist or orthoptist, as applicable, and You. We do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section. When we do cover a prosthetic and orthotic device, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a prosthetic or orthotic device. If we cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally Implanted Devices
We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, Osseo integrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by Us and if all of the following requirements are met:

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

This coverage also includes, for a cochlear implant, an external speech processor and controller with necessary component replacement every three years. Additionally, one cochlear implant for each ear, with internal replacement, will be covered as medically or audiologically necessary.

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

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

- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Prosthetic devices and installation accessories to restore a method of speaking following the

removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months when required to hold a prosthesis.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Prostheses used to replace a missing part (such as a hand, arm, or leg) that is needed to alleviate or correct illness, injury, or congenital defects, including braces (not orthodontic braces), limited to medically appropriate equipment and subject to Prior Authorization. Repair or replacement of such prostheses is a Covered Service only when Medically Necessary and subject to Prior Authorization.

All of the following requirements must be met for the devices to be covered:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets Your medical needs
- You receive the device from the provider or vendor that Molina Healthcare selects For external devices, Durable Medical Equipment Cost Sharing will apply.

Home Healthcare
We cover these home health care services – i.e., health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness – when such services are Medically Necessary and approved by Molina Healthcare:

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

The following home health care services are covered under Your product:

- Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and
- One visit is considered four hours per visit by a home health aide or representative of a home health agency
- 60 visits per plan year (counting all home health visits)

Please refer to the “Exclusions” section of this EOC for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation
We cover Emergency medical transportation in an emergency medical services vehicle (ground and air ambulance) licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), or ambulance transport services provided through the "911" emergency response system when Medically Necessary. Such services are considered emergency care if they are provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that the failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus. 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.

HEARING SERVICES

We cover hearing aids which is limited to one hearing aid for each ear every three years, including fitting and dispensing services. Additionally, coverage also includes the provision of ear molds as necessary to maintain optimal fit of hearing aids; related treatments including habilitation and rehabilitation necessary for educational gain. We also cover internally implanted devices as described in the "Prosthetic and Orthotic Devices" section. Please see your Schedule of Benefits for Copayment amount.

We do cover the following:

- Routine hearing screenings that are Preventive Care Services: no charge
    - which includes a screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code

Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age: Cost Share applies

OTHER SERVICES

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

- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina Healthcare.

- A Participating Provider physician provides a written Referral for care at the facility

Diabetes Management Services
We cover expenses for the nutritional, educational, and psychosocial treatment of the Qualified Member. Such Diabetes Management Services/Diabetes Self—Management Training for which a physician or Other Participating Provider has written an order to the Member or caretaker of the Member is limited to the following when rendered by or under the direction of a Participating Physician.

Initial and follow-up instruction concerning:

(1) The physical cause and process of diabetes;

(2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

(3) Prevention and treatment of special health problems for the diabetic patient;

(4) Adjustment to lifestyle modifications; and

(5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the Qualified Member includes the development of an individualized management plan. This is created for the Qualified Member and family to understand the care and management of diabetes. This includes nutritional counseling and proper use of diabetes equipment and supplies.

A Qualified Member under this plan has been diagnosed with:
(a) insulin dependent or non-insulin dependent diabetes
(b) elevated blood glucose levels induced by pregnancy
(c) another medical condition associated with elevated blood glucose levels.

COVERED SERVICES FURNISHED WHILE TRAVELING OUTSIDE THE SERVICE AREA (INCLUDING OUTSIDE OF THE UNITED STATES)
Your Covered Services include Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United StatesIf You require Emergency Services while traveling outside the United States, please use that country's or territory's emergency telephone number or go to the nearest emergency room.

If You receive health care services while traveling outside the United States or outside the Service Area, You will be required to pay the Non-Participating Provider's charges at the time You obtain those services. You may submit a claim for reimbursement to Molina Healthcare for charges that You paid for Covered Services furnished to You by the Non-Participating Provider. Members are responsible for ensuring that claims and/or records of such services are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. Medical records of treatment/service may also be required for proper reimbursement from Molina.

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

Molina Healthcare
PO Box 22719
Long Beach, CA 90801

Claims for reimbursement for Covered Services while You are traveling outside the United States must

be verified by Molina Healthcare before payment can be made. Molina will reimburse for the usual and customary rate or rate agreed to with the provider for Emergency Services incurred while traveling outside of the Service Area, in accordance with applicable state and federal laws.

Because these services are performed by a Non-Participating Provider You will only be reimbursed for the usual and customary rate or at the rate agreed to with the provider, which may be less than the amount You were charged by the Non-Participating Provider. You will not be entitled to reimbursement for charges for health care services or treatment that are excluded from coverage under this EOC, specifically those identified in "Services Provided Outside the United States (or Service Area)" in the "Exclusions" section of this EOC.

Please see section How Does Molina Healthcare Pay for My Care? of this EOC for additional details regarding how Molina Healthcare processes claims from Members.

Tele-medicine Medical Services and Tele-health Services
We cover Tele-medicine Medical Services and Tele-health Services as any other comparable Outpatient Professional Covered Services when provided by Participating Providers and when a face-to-face consultation is not practical. Applicable Copayment applies.

EXCLUSIONS

What is Excluded from Coverage Under My Plan?
This "Exclusions" section lists specific items and services excluded from coverage under this EOC. These exclusions apply to all services that would otherwise be covered under this EOC regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Acupuncture
Acupuncture services or supplies are not covered.

Artificial Insemination and Conception by Artificial Means
All services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Bariatric Surgery
Bariatric surgery is not covered. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an inpatient stay or an extended inpatient stay for the bariatric surgery, as determined by Molina, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Molina plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Agreement. Directly related means that the inpatient stay or extended inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

Certain Exams and Services
Physical exams and other services 1) required for obtaining or maintaining employment or participation in employee programs, 2) required for insurance or licensing, or 3) on court order or required for parole or probation. This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary.

Cosmetic Services
Services that are intended primarily to change or maintain Your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "What is Covered Under My Plan?" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial Care
Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing,

dressing, feeding, toileting, and taking medicine).

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

Dental and Orthodontic Services
Dental and orthodontic services such as x-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

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

Dietician
A service of a dietician is not a covered benefit. This exclusion does not apply to services under hospice care or for Covered Services described in the section titled, "Phenylketonuria (PKU) and other Inborn Errors of Metabolism, or Diabetes Services."

Disposable Supplies
Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, under pads, and other incontinence supplies.

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

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

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

This exclusion does not apply to any of the following:

- Services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan?" section

Please refer to the "Independent Review Organization" (IRO) section for information about Independent Review Organization (IRO) reviews related to denied requests for Experimental or Investigational services.

Gene Therapy
Molina does not cover gene therapy.

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

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

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

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

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

Items and Services to Correct Refractive Defects of the Eye
Items and services (such as eye surgery or contact lenses to reshape the eye) for correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section.

Massage Therapy and Alternative Treatments
We do not cover alternative treatments including, but not limited to, massage therapy, aromatherapy, or hypnotherapy.

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.

This exclusion does not apply to any of the following:

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

Pregnancy Termination
Elective abortions are not covered. Only abortions due to a medical emergency as defined by section 171.002 of the Texas Health and Safety Code, are covered.

Residential Care
Care in a facility where You stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery services covered under the "Substance Abuse Disorder Services" section.

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

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

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

Please refer to the "Independent Review Organization (IRO) Denials of Experimental/Investigational Therapies" section for information about Independent Review Organization (IRO) reviews related to denied requests for Experimental or Investigational services.

Utilization Review (UR) and Independent Organization Review (IRO) apply to adverse benefit determinations and denials for healthcare services based on both, medical necessity or experimental or investigational.

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

Services Related to a Non-Covered Service
When a Service is not covered, all services related to the non-Covered Service are excluded; except for services, Molina Healthcare 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 Healthcare would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina Healthcare would cover any services that Molina Healthcare would otherwise cover to treat that complication.

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

Surrogacy
Services for anyone in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel and Lodging Expenses
Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina's travel and lodging guidelines. Molina Healthcare's travel and lodging guidelines are available from Our Customer Support Center by calling toll free at 1(888) 560-2025. You may call Our dedicated TTY for the deaf or hard of hearing toll-free at (800) 735-2989. You may dial 711 for the Telecommunications Service.

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

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

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

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

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

WORKERS' COMPENSATION

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

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

RENEWAL AND TERMINATION

How Does my Molina Healthcare Coverage Renew?
Coverage shall be renewed on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. You must follow the procedures required by the Marketplace to redetermine Your eligibility for enrollment every year during the Marketplace's annual open enrollment period.

Changes in Premiums, Copayments and Covered Services:
Any change to this Agreement, including, but not limited to, changes in Premiums, Covered Services, Copayments 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. Such changes can be made no more frequently than one time per plan year.

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 Healthcare (for example, if Your termination date is July 1, 2020, Your last minute of coverage was at 11:59 p.m. on June 30, 2020). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina, including Premiums, for the period prior to Your termination date.

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

Your membership with Molina Healthcare will terminate if You:

- **Cancel Your Coverage Within 10 Days**: You have 10 calendar days to examine this EOC. You may cancel Your coverage within 10 days of Your signing this Agreement and Molina Healthcare will refund Your premium. If Covered Services are received by any Member during this 10-day examination period, then the Subscriber must pay the full cost of those Covered Services if his or her premium has been returned.
- **No Longer Meet Eligibility Requirements:** You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina Healthcare or the Marketplace. You no longer live, reside, or work in Molina Healthcare's Service Area for this product. 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 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 Healthcare 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. Molina Healthcare may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.
- **Change the Marketplace Health Plans**: You decide to change from Molina Healthcare to another health plan offered through the Marketplace if You timely cancel Your coverage under this EOC within 10 calendar days of Your from the Effective Date of Your coverage if You are not satisfied with Molina Healthcare, or
    - 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.
- **Fraud or Misrepresentation**: You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina Healthcare. A notice of termination will be sent to you 15 days before cancellation of coverage for fraud or misrepresentation. Some examples include:
    - Making a misrepresentation of a material fact on the enrollment application. Molina will not use a statement on the enrollment application to void, cancel or non-renew Your coverage or reduce Your benefits unless (1) the statement is in a written application signed by the Subscriber and (2) a signed copy of the application is or has been furnished to the Subscriber or the Subscriber's personal representative.
        - Misrepresenting eligibility information.
        - Presenting an invalid prescription or physician order.
        - Misusing a Molina Healthcare Member ID Card (or letting someone else use it).

After Your first 24 months of coverage, Molina Healthcare may not terminate Your coverage due to any intentional omissions, misrepresentations, or inaccuracies in Your application form.

If Molina Healthcare terminates Your membership for cause, You may not be allowed to enroll with us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

- **Discontinuation:** If Molina Healthcare ceases to provide or arrange for the provision of health benefits for new or existing health care service in the individual market, in which case Molina Healthcare 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 Healthcare will provide You with written notice at least 90 days prior to the date the coverage will be discontinued. Molina will offer to each member on a guaranteed-issue basis any other individual basic health care coverage offered by Molina in the service area.
- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina Healthcare may terminate Your coverage as further described below.

Your coverage under certain Covered Services will terminate if Your eligibility for such benefits end. If only certain Covered Services end because a Member attains a certain age, then coverage of those benefits under this EOC will end at 11:59 p.m. on the last day of the calendar year in which the Member has reached the limiting age, without affecting that Member's coverage under the remainder of this EOC.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

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

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

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

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

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

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

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

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

Reinstatement after Termination

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

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

YOUR RIGHTS AND RESPONSIBILITIES

What are My Rights and Responsibilities as a Molina Healthcare Member?
These rights and responsibilities are posted on the Molina Healthcare web site: www.molinahealthcare.com.

YOUR RIGHTS
You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina Healthcare.
- Get information about Molina Healthcare, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina Healthcare's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).
- Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*
- Complain about Molina Healthcare or Your care. You can call, fax, e-mail, or write to Molina Healthcare's Customer Support Center.
- Appeal Molina Healthcare's decisions. You have the right to have someone speak for You during
  Your grievance.
- Disenroll from Molina Healthcare (leave the Molina Healthcare product).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina Healthcare to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get interpreter services on a 24-hour basis at no cost to help You talk with Your doctor or with us if You prefer to speak a language other than English.

- Get information about Molina Healthcare, Your providers, or Your health in the language You prefer.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.
- Receive instructions on how You can view online, or request a copy of, Molina Healthcare's non- proprietary clinical and administrative policies and procedures.
- Get a copy of Molina Healthcare'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 Healthcare's contracted hospitals.
- Not to be treated poorly by Molina Healthcare or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish, or seek revenge.
- File a grievance or complaint if You believe Your linguistic needs were not met by Molina Healthcare.

*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) 560-2025.
- Give information to Your doctor, provider, or Molina Healthcare that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed on with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina Healthcare card when getting medical care. Do not give Your card to others. Let Molina Healthcare 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 Healthcare's Customer Support Center toll-free at 1 (888) 560-2025. We are here Monday through Friday, between 8:00 a.m. and 6:00 p.m. CT.

MOLINA HEALTHCARE SERVICES

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

If You would like to learn more about what We are doing to improve, please call Molina Healthcare toll-free at 1 (888) 560-2025 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 EOC.

New Technology
Molina Healthcare is always looking for ways to take better care of Our Members. We have a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

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

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

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

Note that You may be liable to pay for the full price of medical services when:
- You ask for and get medical services that are not covered, such as cosmetic surgery.
- You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Your PCP or Molina Healthcare. The exceptions are in the case of Emergency Services or when medically necessary care is not available from in-network physicians or providers

If Molina Healthcare fails to pay a Molina contracted provider (also known as a Participating Provider) for giving You Covered Services, You are not responsible for paying the provider for any amounts owed by us. This is not true for non-Participating Providers who are not contracted with Molina Healthcare. Benefits for services provided to Your minor Dependent child may be paid to a third party if:
- the third party is named in a court order as the managing or possessory conservator of the child; and
- Molina Healthcare has not already paid any portion of the claim.

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

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

What if I have paid a medical bill or prescription?

(Reimbursement Provisions)

While most claims for payment of Covered Services will be submitted directly by Your Participating Providers, You may incur charges for Covered Services can be submitted by You as a claim to Molina Healthcare. For example, you may have received Emergency Services from a no-Participating Provider.

With the exception of any required Cost Sharing amounts (such as a Copayment), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina Healthcare will pay You back. You will need to mail or fax us a copy of the bill from the doctor, hospital, or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on Welcome page of this EOC.

You must provide us with notice of a claim within 20 days following the date of service, unless it is not reasonably possible to do so. Failure to give notice within this time will not invalidate or reduce any claim if You show that it was not reasonably possible to give the notice, and that the notice was given as soon as it was reasonably possible. Within 15 days following Our receipt of the notice of claim, We will acknowledge the receipt of the claim, begin Our investigation of the claim, and request any additional items, statements, and forms that We reasonably believe will be required from You. All claims must be properly submitted within 90 days of the date that You receive the services or supplies. Claims not submitted and received by Molina Healthcare within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

If the bill is for a prescription drug, You will need to include a copy of the prescription drug label. Mail this information to Molina Healthcare's Claims department:

Molina Healthcare
PO Box 22719
Long Beach, CA 90801

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 Healthcare toll-free at:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P.O. Box 165089
Irving, TX 75038

After We receive Your claim, We will notify You in writing of the acceptance or rejection of the claim within 15 business days after We receive all the information We need to process the claim. If We need additional time, We will notify You of the reasons We need more time, and will accept or reject the claim within 45 days. If Your claim is accepted, We will mail You a check within 5 business days after We have notified You. If You do not agree with Our decision, You may appeal Our decision as explained under the Complaints and Appeals section of this EOC.

How Does Molina Healthcare Pay for My Care?
Molina Healthcare contracts with providers in many ways. Some Molina Healthcare Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina Healthcare does not provide financial incentives for utilization management decisions that could result in Referral denials or under-utilization. For more information about how providers are paid, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-2025. We are here Monday through Friday, 8:00 a.m. to 6:00 p.m. CT. You may also call Your provider's office or Your provider's medical group for this information.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. 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 accord with its EOC 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 equal 100 percent of the total allowable expense.

DEFINITIONS

(a) 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, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool;

workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic
injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies.

Each contract for coverage under (a)(1) or (a)(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.
(b)"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 like benefits, and may apply other separate COB provisions 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 equal 100 percent of the total allowable expense.

(c)"Allowable expense" is a health care expense, including 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 health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:
(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, Allowed Amounts, or relative value schedule reimbursement methodology, or other similar reimbursement
methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, Allowed Amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician 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 health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The Allowed Amount includes both the carrier's payment and any applicable Copayment amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or Referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, 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 under any other plan.

(b)Except as provided in (c), a plan that does not contain a COB provision that is consistent with this EOC is always primary unless the provisions of both plans state that the complying plan is primary.

(c)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 must 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.

(d)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.

(e)If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized Referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides

benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other.
Each secondary plan must
take into consideration the benefits of the primary plan or plans and the benefits
of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent 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, 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. An example includes a retired employee.
(2) Dependent Child Covered Under More Than one Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

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

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

(i) if a court order 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 order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order 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 (h)(2)(A) must determine the order of benefits.

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

(I)the plan covering the custodial parent;
(II) the plan covering the spouse of the custodial parent;
(III) the plan covering the noncustodial parent; then
(IV) the plan covering the spouse of the noncustodial 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 (h)(2)(A) or (h)(2)(a) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, 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 that covers 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 plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under 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, 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 does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must 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

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans 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 equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan any amounts it would have credited in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws concerning confidential 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 Healthcare will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Molina Healthcare any facts it needs to apply those

rules and determine benefits.

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 Healthcare 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. Molina Healthcare 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 [organization responsible for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. 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 Texas Department of Insurance for instructions on filing a consumer complaint. Call **1- 800-252-3439**, or visit Texas Department of Insurance website at www.tdi.texas.gov
.

INTERPRETER SERVICES

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

Molina Healthcare offers telephonic interpreter services to help You with:

- Making an appointment
- Talking with Your doctor or nurse
- Getting Emergency care in a timely manner
- Filing a complaint or grievance
- Getting health management services
- Getting information from the pharmacist about how to take Your medicine (drugs)

Tell Your doctor or anyone who works in his or her office if You need an interpreter. You may also ask for any of the documents that Molina Healthcare sends You in Your preferred written language. Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Molina Healthcare's Customer Support Center at 1 (888) 560-2025.

Cultural and Linguistic Services
Molina Healthcare can help You talk with Your doctor about Your cultural needs. We can help You find doctors who understand Your cultural background, social support services and help with language needs. Please call Molina Healthcare's Customer Support Center at 1 (888) 560-2025.

COMPLAINTS AND APPEALS

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER.

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL CALL: 1-800-832-9623. YOUR COMPLAINT WILL BE REFERRED TO THE STATE AGENCY THAT REGULATES THE HOSPITAL OR CHEMICAL DEPENDENCY TREATMENT CENTER

Member Grievance and Appeal Procedure
Molina Healthcare's Grievance and Appeal Procedure is overseen by Our Grievance and Appeal Unit. Its purpose is to resolve issues and concerns from Members. We will provide You a written copy of Our grievance and appeal process upon request. We will never retaliate against a Member in any way for filing a grievance or appeal. For the purposes of this section, any reference to "You", "Your" or "Member" also refers to a representative or health care provider designated by You to act on Your behalf, unless otherwise noted.

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

filed with Molina or the Texas Department of Insurance in the manner described in the Internal Appeals section below.

What if I Have a Complaint?
If You have a problem with any Molina Healthcare services, We want to help fix it. You can call any of the following toll-free for help:

- Call Molina Healthcare toll-free at 1-866-449-6849. We are here Monday through Friday, 8:00 a.m. - 6:00 p.m. CDT. Deaf or hard of hearing Members may call Our toll-free TTY number at 1 (800) 735-2989. You may also contact us by calling the National Relay Service at 711.

- You may also send us Your problem or complaint in writing by mail or filing online at Our website. Our address is:
  Molina Healthcare of Texas
  Attn: Member Complaints & Appeals
  P.O. Box
  165089 Irving,
  TX 75038

Molina Healthcare recognizes the fact that Members 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 problems and complaints. You may file a grievance (also called a complaint) in person, in writing, or by telephone as described above. Molina Healthcare also will provide oral language services that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language. You can request that any notice from Molina Healthcare be provided in any applicable non-English language. With respect to any Texas county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language as determined by the Department of Health and Human Services (HHS).

Complaints -We will send You a letter acknowledging receipt of Your grievance within 5 days of receipt of the complaint. Grievances will be resolved within thirty (30) calendar days from receipt of the complaint. A complaint or grievance concerning disagreement or dissatisfaction with an Adverse determination constitutes an appeal of that Adverse determination. Appeals of Adverse determinations

will be resolved as noted below.

Appealing Resolution of Complaints – If You are not satisfied with the resolution of Your complaint, You may appeal that resolution in writing. You may request to appear in person before a complaint appeal panel or address a written appeal to the complaint appeal panel. If You appeal the resolution of a Complaint, We will send an acknowledgment letter to You not later than the fifth business day after We receive Your written request for appeal. We will complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

If you appeal Your complaint resolution, We will appoint members to a complaint appeal panel to advise us on the resolution of a disputed decision appealed. The complaint appeal panel will be composed of an equal number of Molina staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision. The physicians or other providers on a complaint appeal panel will have experience in the area of care that is in dispute and must be independent of any physician or provider who made any previous determination. If specialty care is in dispute, the complaint appeal panel will include a person who is a Specialist Physician in the field of care to which the appeal relates. The enrollee members of a complaint appeal panel will not be employees of Molina

Adverse determinations

An **"Adverse determination"** means a determination by Molina Healthcare that health care services provided or proposed to be provided to a Member are not Medically Necessary or are Experimental or Investigational. The term “Adverse Determination” does not include the denial of health services due to failure to request prospective or concurrent utilization review. A rescission of coverage is also an Adverse Determination. A rescission does not include a termination of coverage for reasons related to nonpayment of premium.
Adverse determination

Molina shall provide notice of an adverse determination as follows:

(1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;

(2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or

(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

The notice of an adverse determination will include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria used as guidelines in making the adverse

determination;

(4) the professional specialty of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.1705 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination);

(7) a copy of the request for a review by an IRO form, available at www.tdi.texas.gov/forms;

(8) notice of the independent review process with instructions that:

(A) request for a review by an IRO form must be completed by the enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the insurance carrier or URA that made the adverse determination to begin the independent review process; and

(B) the release of medical information to the IRO, which is included as part of the independent review request for a review by an IRO form, must be signed by the enrollee or the enrollee's legal guardian; and

(9) a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an enrollee who

(A) has a life-threatening condition.
(B) is requesting prescription drugs or intravenous infusions

If the denial involves a life-threatening condition, the notice will also include a description of Your right to an immediate review by an independent review organization and of the procedures to obtain that review.

In the case of an adverse determination resulting from a retrospective review Molina will provide written notice to the member, within 30 days after the claim is received. Retrospective reviews may take up to an additional 15 days.

You may request an Appeal of an Adverse determination

APPEAL PROCEDURES FOR ADVERSE DETERMINATIONS (INCLUDING EXPEDITED CLINICAL APPEALS)

Expedited Clinical Appeals

If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to health care services, including but not limited to, Prior Authorization for treatment, denial of emergency care or concurrent or continued hospitalization. Before authorization of benefits for an ongoing course of treatment or concurrent or continued hospitalization is terminated or reduced, Molina Healthcare will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process. The procedure will include a review by a health care provider who has not previously reviewed the case and is of the same specialty or a similar specialty as the health care provider who would typically manage the condition under appeal.

Molina Healthcare will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by Molina Healthcare.

Expedited Prescription Drug and Intravenous Infusion Appeals

Molina will investigate and resolve appeals relating to prescription drugs and intravenous infusions for which the Member is receiving benefits within one business day from the date all information necessary to complete the appeal is received. Such appeals will be reviewed by a health care provider who:

(1) Has not previously reviewed the case; and
(2) Is of the same or similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

How to Appeal an Adverse determination

An appeal of an Adverse determination may be filed by You or a person authorized to act on Your behalf, or Your health care provider. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call Molina Healthcare at 1 (888) 560-2025. Molina Healthcare will review its decision in accordance with the following procedure:

- Within 180 days after You receive notice of an Adverse determination, You may call or write to Molina Healthcare to request an appeal. We will need to know the reasons why You do not agree with the Adverse determination. Send Your request to:

For review of claims for payment or reimbursement:

Molina Healthcare of Texas, Inc.
5605 MacArthur Blvd, Suite 400
Irving, TX 75038

For appeal requests for services, including Prior Authorization:
Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P.O. Box 165089
Irving, TX 75038

We also will take telephone requests for an appeal. Within 5 working days from the date We receive Your appeal, We will send You a letter acknowledging the date of receipt, the procedures to be followed in the appeal and a list of documents that You must submit for review. When We receive an oral appeal, We will send You a short appeal form. In support of Your appeal, You have the option of presenting evidence and testimony to us. You and Your authorized representative may ask to review Your file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of an Adverse determination or at any time during the appeal process. A physician will make the appeal decision.

Molina Healthcare will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of Your appeal without regard to whether such information was considered in the initial determination.

We will not rely on the initial Adverse determination. Any new or additional evidence or rationale will be provided to You or Your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give You a chance to respond.

If you have any questions about the appeals procedures, write to us at the above address or call us at1-866-449-6849. This appeal process does not prohibit you from pursuing civil action available under the law.

Timing of Appeal Determinations

Molina Healthcare will make a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by us.

.**Notice of Appeal Determination**

Molina Healthcare will notify the party filing the appeal, You, and, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice will include:

- The clinical basis for the determination;

- a statement of the specific medical, dental, or contractual reasons for the resolution;
- a description of or the source of the screening criteria that were utilized in making the determination;
- notice of the appealing party's right to seek review of the adverse determination by an IRO under
- §19.1717 of this title (relating to Independent Review of Adverse Determinations);
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- The specialty of the physician or other health care provider making the determination;
- In certain situations, a statement in non—English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non—English language(s) and how to access Molina Healthcare's language services; If the decision is a denial, the specialty of the physician or other health care provider making the denial; and
- An explanation of Molina Healthcare's external review process to an Independent Review Organization (and how to initiate an external review of the determination).

Your external review rights are described below in the ***Appeal to an Independent Review Organization (IRO)*** section below.

APPEAL TO AN INDEPENDENT REVIEW ORGANIZATION (IRO)

You may request an appeal to an Independent Review Organization ("**IRO**") of a denial of an appeal of an Adverse determination made by Molina Healthcare.

This procedure is not part of the complaint process and pertains only to appeals of Adverse determinations. In addition, in life-threatening or urgent care circumstances, You are entitled to an immediate appeal to an IRO and are not required to comply with Molina Healthcare's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by Molina Healthcare may seek review of the decision by an IRO. At the time the appeal is denied, We will provide You, Your designated representative, or Provider of record, information on how to appeal the denial, including any approved form, which You, Your designated representative, or Your provider of record must complete. In life- threatening or urgent care situations, You, Your designated representative, or Your provider of record may contact Molina Healthcare by telephone to request the review and provide the required information. For all other situations, You or Your designated representative must request the IRO review in writing to Molina Healthcare to begin the independent review process.

- Molina Healthcare will submit medical records, names of providers and any documentation pertinent to the decision of the IRO within 3 business days of receiving Your request for an IRO review.
- Molina Healthcare will comply with the decision by the IRO.
- Molina Healthcare will pay for the independent review.

Upon request and free of charge, You or Your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by Molina Healthcare;
- medical judgments, including whether a particular service is Experimental or Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by Molina Healthcare in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit You from pursuing other appropriate remedies, including: injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places Your health in serious jeopardy. OTHER

MISCELLANEOUS PROVISIONS

CONTINUANCE OF COVERAGE DUE TO CHANGE IN MARITAL STATUS

If You loses coverage due to a change in marital status, You shall be issued a new EOC by Molina that is effective prior to the change in marital status. The new EOC will be issued without evidence of insurability in accordance with State Law and will have the same effective date as the EOC under which coverage was afforded prior to the change in marital status.

Acts Beyond Molina Healthcare's Control
If circumstances beyond the reasonable control of Molina Healthcare, 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 Healthcare and the Participating Provider 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 Healthcare 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 Healthcare'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 Healthcare's right to require Your performance of any provision of this Agreement.

Non-Discrimination
Molina Healthcare does not discriminate in hiring staff or providing medical care based on pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity. If You think You have not been treated fairly please call the Customer Support Center toll-free at 1(888) 560-2025.

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 making that selection when you renew Your Driver's License or pick up a form at Your nearest Department of Public Safety office, or you can go online at www.donatelifeTexas.org to register.

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

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

Molina's discretion).

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

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

Notices
Any notices required by Molina Healthcare under this Agreement will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for reporting any change in address by contacting [the Marketplace] at [1 (800) 318-2596].

WELLNESS PROGRAM

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

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

Annual Wellness Exam

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

Program Benefit
For participating and completing the annual health activity, you will receive a program benefit gift card.. Maximum program benefit is one gift card, per calendar year. You will receive the program benefit gift card by mail at the mailing address that is on file with Molina:

Annual Health Activity	Annual Program Benefit
Complete an Annual Wellness Exam	**Receive a $50 Gift Card**

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

You can enroll in any of the programs above by calling the Molina Healthcare Health Management Department at **1(866) 891-2320, between 5:00 a.m. and 9**:00 p.m. (MT), Monday through Friday.

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Newsletters

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

Health Education Materials

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

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

IF YOU RECEIVE A BILL, OTHER THAN FOR YOUR COST SHARING AS SHOWN IN THE SCHEDULE OF BENEFITS, FROM YOUR PROVIDER (BALANCE BILL), YOU SHOULD CONTACT MOLINA'S MEMBER SERVICES DEPARTMENT AT THE PHONE NUMBER ON YOUR ID CARD

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in Your health plan insured by Molina Healthcare of Texas, Inc. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Molina Healthcare at 1-888-560-2065*

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

a. 48 hours following a mastectomy; and
b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not:
(a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
(b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
(c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
(d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Copayment amounts will be the same as those applied to other similarly covered Inpatient Hospital Expense or Medical-Surgical Expense, as shown on the Schedule of Coverage.

Prohibitions: We may not:
(a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
(b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or
(c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Examinations for the Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

a. A physical examination for the detection of prostate cancer; and
b. A prostate-specific antigen test for each covered male who is:
   (1) At least 50 years of age; or
   (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, We will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:
a. 48 hours following an uncomplicated vaginal delivery; and
b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:
a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, We will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast—feeding and bottle—feeding and the performance of any necessary and appropriate clinical tests. Care is provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions:

We may not:
(a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
(b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
(c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
(d) reduce payments or reimbursements below the usual and customary rate; or
(e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

For each woman enrolled in the plan who is 18 years of age or older, expenses are covered for an annual medically recognized diagnostic examination for the early detection of Ovarian Cancer and cervical cancer. Coverage required under this section includes at a minimum a CA 125 blood test; and a conventional Pap smear screening or a screening using liquid—based

cytology methods. The method must be approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

Your health benefit plan coverage for an acquired brain injury includes the following services:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan that has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the Member or Subscriber to receive the preceding treatments or services commensurate with their condition. Post-acute treatment or services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

YOUR HEALTHCARE QUICK REFERENCE GUIDE

Department/Program	Type of help needed	Number to call/ Contact information
Molina Healthcare Customer Support Center Department	If You have a problem with any of Molina Healthcare's services, we want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00 am to 5:00 pm. MT. When in doubt, call Us first.	Customer Support Center Toll Free: 1 (888) 560-2025 TTY line for the deaf or hard of hearing: 1 (800) 735-2989 or dial 711 for the Telecommunications Service
Health Management	To request information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes. To request any information on programs for conditions such as asthma, diabetes, high blood pressure, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD)	1 (866) 472-9483 between 5:00 a.m. and 9:00 p.m. (CDT) 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
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).	(Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE TTY for deaf or hard of hearing: 1 (877) 486-2048 **www.Medicare.gov**
Texas Department of Insurance	The Texas Department of Insurance is responsible for regulating health care services plans. If You have a grievance against Molina Healthcare, You should first call Molina Healthcare toll-free at 1-888-560-2025, and use Molina Healthcare's grievance process before contacting this department.	1-**800-252-3439** Web: http:// www.tdi.texas.gov E-mail: Consumerprotection@tdi.texas.gov

Molina Healthare of Texas, Inc. Service Area Map
Cameron, Collin, Dallas, El Paso, Harris, Hidalgo, Jefferson, Starr and Webb Counties.