# 2016

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

## Molina Marketplace Standard 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.

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

MolinaHealthcare.com/Marketplace

MHT01012016ST

## 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.

# MOLINA HEALTHCARE OF TEXAS, INC.
# SCHEDULE OF BENEFITS

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

**NOTICE: THIS PRODUCT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. COVERAGE FOR PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE ON A STANDALONE BASIS THROUGH THE HEALTH INSURANCE MARKEPLACE. PLEASE CONTACT THE HEALTH INSURANCE MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL SERVICES.**

Except for Emergency Services, out-of-area Urgent Care Services, and Medically Necessary Prior Authorization, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to the Out-of-Pocket Maximum.

| Annual Out of Pocket Maximum* | At Participating Providers, You Pay |
|---|---|
| **Individual** | $6,850 |
| **Entire Family of 2 or more** | $13,700 |

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

| Emergency Room and Urgent Care Services** | You Pay | |
|---|---|---|
| **Emergency Room*** | $300 | Copayment per visit |
| **Urgent Care** | $60 | Copayment per visit |

*This cost does not apply, if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital Services, for applicable Cost Sharing to You)

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

| Outpatient Professional Services** | At Participating Providers, You Pay | |
|---|---|---|
| **Office Visits** | | |
| Preventive Care (Includes prenatal and first postpartum exam) | No Charge | |
| Primary Care | $20 | Copayment per visit |
| Specialty Care | $60 | Copayment per visit |
| Other Practitioner Care | $20 | Copayment per visit |
| **Habilitative Services**<br>— 35 visits per year for habilitative services (including Habilitative Autism Benefit) | 20% | Coinsurance |
| **Rehabilitative Services** | 20% | Coinsurance |
| **Mental & Behavioral Health Services** | $20 | Copayment per visit |
| **Substance Abuse/Chemical Dependency Services** | $20 | Copayment per visit |
| **Pediatric Vision Services (for Members under Age 19 only)** | | |
| Vision Exam<br>• (Screening and exam, limited to 1 exam each calendar year) | No Charge | |
| **Prescription Glasses**<br>Frames: • Limited to 1 pair of frames every 12 months • Limited to a selection of covered frames | No Charge | |
| Lenses: • Limited to one pair of prescription lenses every 12 months • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • Fashion and gradient tinting, oversized and grey glasses #3 prescription sunglass lenses, • All lenses include scratch resistant coating, UV protection | No Charge | |
| **Prescription Contact Lenses**<br>In lieu of prescription glasses, one pair of prescription contact lenses once every 12 months. Medically Necessary contact lenses for specified medical conditions require prior authorization. | No Charge | |
| **Hearing Aids** Hearing aids costing up to $1,000 (limit 1 hearing aid every 36 months) | No Charge | |
| Hearing aids costing in excess of $1,000 | 20% | Coinsurance |
| **Family Planning** | No Charge | |

****General medical care provided by a Participating Provider**

| Outpatient Hospital / Facility Services | At Participating Providers, You Pay | |
|---|---|---|
| **Outpatient Surgery** | | |
| Professional | 20% | Coinsurance |
| Facility | 20% | Coinsurance |
| Endoscopic Procedures<br>(Medically Necessary exams, tests, and procedures). Endoscopic procedures covered as preventive care services in accordance with the provisions of this EOC are not subject to the Medically Necessary requirement, and such procedures will be at no charge. | 20% | Coinsurance |
| Administration of Injections and Infusion Therapy | 20% | Coinsurance |
| **Specialized Scanning Services** (CT Scan. PET Scan, MRI) | 20% | Coinsurance |
| **Radiology Services** | $60 | Copayment |
| **Chemotherapy** | $60 | Copayment |
| **Laboratory Tests** | $20 | Copayment |
| **Mental & Behavioral Health** | | |
| Outpatient Intensive Psychiatric Treatment Programs | 20% | Coinsurance |

| Inpatient Hospital Services | At Participating Providers, You Pay | |
|---|---|---|
| **Medical / Surgical** | | |
| Professional | 20% | Coinsurance |
| Health Care Facility | 20% | Coinsurance |
| **Maternity Care** (professional and facility services) | 20% | Coinsurance |
| **Mental & Behavioral Health** (Inpatient Psychiatric Hospitalization) | 20% | Coinsurance |
| **Substance Abuse/Chemical Dependency** | | |
| Inpatient Detoxification | 20% | Coinsurance |
| Transitional Residential Recovery Services | 20% | Coinsurance |
| **Skilled Nursing Facility** (limited to 25 days per calendar year) | 20% | Coinsurance |
| **Hospice Care** | No Charge | |

| Prescription Drug Coverage | At Participating Providers, You Pay* | |
|---|---|---|
| **Tier 1 - Formulary Generic Drugs** | $20 | Copayment per 30-day supply |
| **Tier 2 - Formulary Preferred Brand Name Drugs** | $60 | Copayment |
| **Tier 3 - Formulary Non-Preferred Brand Name Drugs** | 20% | Coinsurance |
| **Tier 4 - Specialty Drugs (Oral and Injectable Drugs)** | 20% | Coinsurance |
| **Tier 5 -Formulary Preventive Drugs** | No Charge | |
| **Mail-order Prescription Drugs** (Applies only to Drug Tiers 1, 2, 3 & 5) | Cost sharing for a 90-day supply by mail order is double the cost sharing for a standard 30-day supply. Available for tiers 1,2,3, and 5. | |

*** There are limits to the prescription drug cost-share you pay in certain circumstances. Please refer to Your Evidence of Coverage for more details and a description of prescription drug benefits.**

| Ancillary Services | At Participating Providers, You Pay | |
|---|---|---|
| **Durable Medical Equipment** | 20% | Coinsurance |
| **Home Health Care**(Limited to 60 visits per year) | No Charge | |
| **Emergency Medical Transportation** (Ambulance) (Medically Necessary Emergency Services are covered for Participating and Non-Participating Providers.) | $350 | Copayment |

| Other Services | At Participating Providers, You Pay | |
|---|---|---|
| Dialysis Services | $60 | Copayment |

| Prescription Drug Coverage | **At Participating Providers,** You Pay | |
|---|---|---|
| Tier 1 -Formulary Generic Drugs | [$0-$35] | Copayment per 30-day supply |
| Tier 2 - Formulary Preferred Brand Name Drugs | [$0-$80] | Copayment |
| Tier 3 -Formulary Non-Preferred Brand Name Drugs | [0%-40%] | Percentage of Cost SharingPercentage of Cost Sharing |
| Tier 4 - Specialty Drugs (Oral and Injectable Drugs) | [0%-40%] | Percentage of Cost SharingPercentage of Cost Sharing |
| Tier 5 -Formulary Preventive Drugs | No Charge | |
| Mail-order Prescription Drugs (Applies only to Drug Tiers 1, 2, 3 & 5) | Cost sharing for a 90-day supply by mail order is double the cost sharing for a standard 30-day supply. Available for tiers 1,2,3, and 5. | |

Please refer to “PRESCRIPTION DRUG COVERAGE” section for a description of prescription drug coverage.

| Ancillary Services | At Participating Providers, You Pay | |
|---|---|---|
| Durable Medical Equipment | [0%-40%] | Percentage of Cost SharingPercentage of Cost Sharing |
| Home Health Care (Limited to 60 visits per year) | No Charge | |
| Emergency Medical Transportation (Ambulance)<br>(Medically Necessary Emergency Services are covered for Participating and Non-Participating Providers.) | [$0-$500] | Copayment |

| Other Services | At Participating Providers, You Pay | |
|---|---|---|
| Dialysis Services | [$0-$75] | Copayment |

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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 Benefits and Coverage as described in this Agreement.

This Agreement, riders, and amendments to this Agreement, 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
605 MacArthur Blvd, Suite 400
Irving, TX 75038
1 (888) 560-2025
www.molinahealthcare.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.

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

# 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.molinahealthcare.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
605 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**"
**For Individuals** - is the maximum amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Certificate are specified in the Molina Healthcare of Texas, Inc. Benefits and Coverage Guide. For this Certificate, Cost Sharing includes payments You make towards any Copayments, or Percentage of Cost SharingPercentage of Cost Sharing. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Your Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the individual Annual Out-of-Pocket Maximum.

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

"**Authorization or Authorized**" (also referred to as "approval" or "Prior Authorization") means a decision to approve specialty or other Medically Necessary care for a Member by the Member's PCP or medical group.

"**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 Policy that is obtained by a responsible adult to provide benefit coverage only to a child under the age of 21.

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

"**Copayment**" is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Texas Schedule of Benefits. Some Covered Services do not have a Copayment, and may apply a Percentage of Cost SharingPercentage of Cost Sharing.

“**Cost Sharing**” is the Copayment, and/or Percentage of Cost SharingPercentage of 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.

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

“**Emergency**” or “**Emergency Medical Condition”** means the 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**” mean health care procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that 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
- Disfigurement to the person
- For a pregnant woman, results 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. Standard medical treatment
"**FDA**" means the United States Food and Drug Administration.

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.

**"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**”) 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 specialist physicians or for other services. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctor who usually can see the whole family.
- Internal medicine doctor, who usually only 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 1) a Primary Care Doctor, 2) an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor, or 3) and Other Practitioner who within the scope of his or her license is authorized to provide primary care services.

“**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 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 in 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.

"**Urgent Care Services"** mean medically necessary health care services provided in an Emergency or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention.

# 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 Molina Healthcare and/or the Marketplace.

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

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

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

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

**Who is Eligible?**
To enroll and stay enrolled You must meet all of the eligibility requirements. These are set by the Marketplace. Check the Marketplace's website at [healthcare.gov] for these requirements. Molina requires You to live in Our Service Area for this product with the exception of any child for whom the Subscriber must provide medical support by a medical support order. 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 Policy. 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 child for whom the Subscriber must provide medical support by a medical support order.. 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 Disabled or Handicapped Children:** 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.

Molina will provide the Subscriber with notice at least 90 days before the enrolled child reaches the limiting age. At this time, the Dependent child's coverage will end. The Subscriber must give Molina proof of his or her child's incapacity and dependence within 31 days after the child has reached the limiting age.. This must occur in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina Healthcare. Molina Healthcare may require annual proof of continued incapacity and dependency, following the two-year period after the child's attainment of age 26.

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 Molina Healthcare and/or the Marketplace and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to Molina Healthcare and/or the Marketplace within 60 days from the date the Dependent became eligible to enroll with Molina Healthcare.

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

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

- The Spouse loses "minimum essential coverage" through:
  - Government sponsored programs,
  - Employer-sponsored plans,
  - 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.
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
- The child permanently moves into the service area.

**Newborn Child**: Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth).

**Adopted Child**: A newly adopted child or child placed with You or Your Spouse for adoption is the date the child has become the subject for a suit for adoption or placement for adoption or when You or Your Spouse gain the legal right or responsibility to control the child's health care was gained, whichever date is earlier.

If You do not enroll the adopted child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days. This includes 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. 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.

**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.

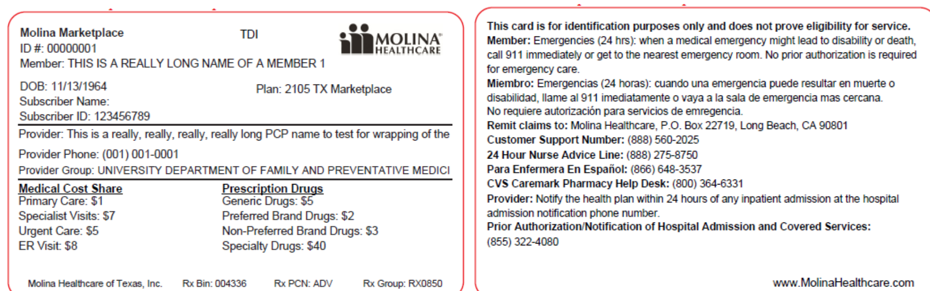
**Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:**
Annual change to this Agreement are effective after 60 days' notice to the Subscriber's address of record with Molina Healthcare. This includes changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Percentage of Cost SharingPercentage of Cost Sharing and Annual Out-of-Pocket Maximum amounts.

# MEMBER IDENTIFICATION CARD

**How do I Know if I am a Molina Healthcare Member?**
You get a Member identification card (ID card) from Molina Healthcare. Your ID card comes in the mail within 10 business days after You make your first payment. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, call 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.

**Sample ID card**




**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)
- Your Primary Care Provider's name (Provider)
- Your Primary Care Provider's office phone number (Provider Phone)
- The name of the medical group Your PCP is associated with (Provider Group)
- 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.

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 **www.molinahealthcare.com/marketplace** to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy.

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 or out of area Urgent Care Services in any emergency room or urgent care center.

Except for Emergency Services, out-of-area urgent Care Services, and Medically Necessary Prior Authorized Services. you must receive Covered Services from participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to the Out-of-Pocket Maximum.

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

| **ALWAYS CONSULT YOUR 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.<br>Even when outside Molina Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care. |
| Urgent Care Services | Call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537 for directions. For out-of-area Urgent Care Services You may also go to the nearest urgent care center or emergency room. |
| A physical exam, wellness visit or immunizations | Go to Your PCP |
| Treatment for an illness or injury that is not an Emergency | Go to Your PCP |
| Family planning services, such as:<br>Pregnancy tests<br>Birth control<br>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. |

| 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. |
| 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 is needed. |
| To see a Specialist Physician (for example, cancer or heart doctor) | Go to Your PCP first. If You need Emergency Services or out-of-area Urgent Care Services, refer to the Emergency Care or Urgent Care Services section for details. |
| To have surgery | Go to Your PCP first. If You need Emergency Services or out-of-area Urgent Care Services, refer to the Emergency Care or Urgent Care Services section for details. |
| To get a second opinion | Consult Molina's Provider Directory. You go to Our website at www.molinahealthcare.com**/marketplace** to find a Participating Provider for a second opinion. |
| To go to the Hospital | Go to Your PCP first. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care 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 (doctors, hospitals, Specialist Physicians or medical clinics),

except in the case of Emergency Services or out of area Urgent Care Services. Please see section Emergency Services and Urgent Care Services for more information about the coverage of Emergency Services and out of area Urgent Care Services. If Medically Necessary Covered Services are not available through a Participating Provider, Molina Healthcare will allow a Referral to a non-Participating Provider, upon the request of Your Participating Provider, and 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.molinahealthcare.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), or pregnancy termination services. You should get more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1 (888) 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 made by the 25th of the month will be in effect on the first day of the next calendar month. All changes made on or after the 26th of the month, the effective date will be the first day of the second calendar month. First visit Your doctor. 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 doctor.

**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.molinahealthcare.com/marketplace 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.

If You have been getting care from a doctor that is ending a contract with Molina Healthcare, You may have a right to keep the same doctor for a given time period. Please contact Molina Healthcare's Customer Support Center.

**Continuity of Care Under Special Circumstances**
If You are undergoing treatment for one of the conditions listed below and Your doctor is no longer a Participating Provider with Molina Healthcare, Your doctor may contact Molina Healthcare to request that You stay with the doctor You are now seeing for continuity of care due to special circumstances. 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 following conditions may be eligible for special circumstances continuation of care:

- You have a serious chronic condition or disability. "**Serious Chronic Condition**" means a medical condition due to a disease, illness, or other medical problem or disorder that is serious in nature, and that does either of the following:
- Persists without full cure or worsens over an extended period of time.
- Requires ongoing treatment to maintain remission or prevent getting worse.
- If You have a Serious Chronic Condition or disability, You may be able to stay with the doctor for up to 90 days following termination of the provider agreement.
- You are past the 24th week of pregnancy. Continuation of coverage may extend through the delivery of Your child and applies to immediate postpartum care and a follow-up check-up within the six-week period after delivery.
- You have a terminal illness. You may stay with the doctor or hospital for up to 9 months following termination of the provider agreement.

Eligibility for continuity of care is not based strictly upon the name of Your condition.

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

**24-Hour Nurse Advice Line**

**If You have questions or concerns about 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:

| Appointment Type<br>For PCPs | When You should get the appointment |
|---|---|
| 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 |
| **Appointment Type<br>For Specialist Physicians** | **When You should get the appointment** |
| 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 a request for You to receive a Covered Service from Your doctor. Molina's Medical Directors and Your doctor all work together. They decide on the Medical Necessity before the care or service is given. This is to ensure it is the right care for Your specific condition.

**You do not need Prior Authorization for the following services:**

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

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

- Admission in a hospital or ambulatory care center for dental care.
- All inpatient admissions
- Approved clinical trials surgery
- Certain Ambulatory Surgery Center service (ASC)*
- Certain Durable Medical Equipment*
- Certain injectable drugs And medications not listed on the Molina Drug Formulary*
- Certain outpatient hospital service*
- Certain Mental Health Services*
- Day treatment,
- Electroconvulsive Therapy (ECT),
- Intensive Outpatient Programs (IOP),
- Mental Health Inpatient,
- Neuropsychological and psychological testing,
- Partial hospitalization
- Cosmetic, plastic and reconstructive procedures (in any setting)
- Custom orthotics, custom prosthetics, and braces. Examples are:
- Any kind of wheelchair
- Implanted hearing device
- Scooters
- Shoes or shoe supports
- Special braces
- Dialysis (notification only)

- Drug quantities that exceed the day-supply limit
- Experimental and Investigational procedures
- General anesthesia for dental care in Members 5 years old or older
- Habilitative Services – After 6 visits for outpatient and home settings
- Home health care - After 6 visits for outpatient and home settings
- Hospice inpatient care (notification only)
- Hyperbaric Therapy
- Imaging and special tests Examples are:
- CT (computed tomography)
- MRI (magnetic resonance imaging)
- MRA (magnetic resonance angiogram)
- PET (positron emission tomography) scan
- Low vision follow-up care
- Pain management care and procedures
- Pregnancy and delivery (notification only)
- Radiation therapy and radio surgery Rehabilitative services
- Cardiac and pulmonary rehabilitation Occupational Therapy (After 6 visits for outpatient and home settings)
- Physical Therapy (After 6 visits for outpatient and home settings)
- Speech Therapy (After 6 visits for outpatient and home settings)
- Services Rendered by a Non-Participating Provider
- Specialty pharmacy drugs (oral and injectable)
- 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. This is for non-emergent ground and air ambulance. Must be medically necessary. Examples are special vans service or ambulance.
- Wound Therapy

Any other services listed as needing Prior Authorization in this EOC.
*Call Molina's Customer Support Center at 1 (888) 560-2025 if You need to find out if, Your service needs Prior Authorization.

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.

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 can explain to You how that type of decision is made. We will send You a copy of the approval process if You request it.

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 Molina Healthcare processes requests for urgent specialty services immediately by telephone.

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

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.molinahealthcare.com/marketplace 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.

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

**How do I get Emergency Services?**
Emergency Services are available 24 hours a day, seven days a week for Molina 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 Urgent Care Services or Emergency Services are covered.**

**What if I need after-hours care or Urgent Care Services?**
Urgent Care Services are available when You are within or outside of 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 urgent care center or emergency room.

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 by a Non-Participating Provider**
Emergency Services for treatment of an Emergency Medical problem are subject to cost sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Benefits and Coverage Guide. When services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, Molina Healthcare will calculate the allowed amount that will be covered under this benefit at the usual and customary rate or agreed upon rate. You may be responsible for charges that exceed the usual and customary amount.

## 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.

## BENEFITS AND COVERAGE

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 or need for out-of-area Urgent Care Services, 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 of Cost SharingPercentage of 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. Summary of Benefits at the beginning of this EOC.

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

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

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

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

**Percentage of Cost SharingPercentage of Cost Sharing**

Percentage of Cost SharingPercentage of Cost Sharing is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Percentage of Cost SharingPercentage of Cost Sharing amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Percentage of Cost SharingPercentage of Cost Sharings are listed in the Molina Healthcare of Texas, Inc. Benefits and Coverage Guide. Some Covered Services do not have Percentage of Cost SharingPercentage of Cost Sharing They may apply a Copayment.

**Copayment**

A Copayment is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Texas, Inc. Benefits and Coverage Guide. Some Covered Services do not have a Copayment. They may apply a Percentage of Cost SharingPercentage of Cost Sharing.

**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. Summary of Benefits at the beginning of this EOC. You will be able to determine the Cost Sharing amount You will be required to pay for each type of Covered Service listed.

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

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this EOC, You pay the Cost Sharing in effect on Your admission date. You will pay this Cost Sharing until You are discharged. The services must be covered under Your prior health plan 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 portions of the total Cost Sharing for the Covered Services You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due. The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this EOC. However, You are responsible for paying charges for any health care services or treatment, which are <u>not</u> Covered Services under this EOC.

**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, Percentage of Cost SharingPercentage of Cost Sharing, 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 Benefits and Coverage or 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 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, without Your paying any Cost Sharing:

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

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

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, also known as a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the Affordable Care Act and applicable 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.
Well baby/child care

- Complete health history
- Physical exam including growth assessment
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Basic vision screening (non- refractive)
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Hearing screening
- Immunizations*
- Laboratory tests, including tests for anemia, diabetes, cholesterol and urinary tract infections

- Tuberculosis (TB) screening
- Sickle cell trait screening, when appropriate
- Health management
- 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.)
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21.These include those with special health care needs.)
- Depression screening: adolescents
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation in children when prescribed by a Participating Provider
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns
- Alcohol and Drug Use assessments for adolescents
- Autism screening for children 18-24 months Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Cervical dysplasia screening: sexually active females
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- Hematocrit or hemoglobin screening
- HIV screening: adolescents at higher risk
- Behavioral health assessment for children
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections

*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.

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)
- Cytological Screening (pap smear) for women beginning no later than age 18 (also based on Your health status and medical risk.)
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening
- Osteoporosis screening for women (based on Your age)
- Immunizations
- Laboratory tests for diagnosis and treatment (including diabetes and STD's)
- Health management and chronic disease management
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Hepatitis C screening for adults
- Breastfeeding support, supplies counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing screenings
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA counseling about breast cancer preventive medication
- Chlamydial infection screening: women

- Depression screening: adults
- Dietary evaluation and nutritional counselingSTDs and HIV screening and counseling
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Syphilis screening and counseling (all adults at high risk)
- Gonorrhea screening and counseling (all women at high risk)
- Screening for hepatitis B virus infection in persons at high risk for infection.
- Tobacco use counseling and interventions
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed)
- Screening and counseling for interpersonal and domestic violence: women
- 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.

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:

- Prevention, diagnosis, and treatment of illness or injury
- Office visits (including pre- and post-natal visits)
- Routine pediatric and adult health exams
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Injections, allergy tests and treatments when provided or referred by Your PCP
- Audiology and hearing tests
- Physician and other Practitioner care in or out of the hospital
- Consultations and well child care
- 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
- Routine examinations and prenatal care provided by an OB/GYN to female Members. You may select an OB/GYN as Your PCP.  Female Dependents age 13 and older have direct access to obstetrical and gynecological 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.)
- Osteoporosis services for women (including treatment and appropriate management when such service are determined to be Medically Necessary by the women's PCP, in consultation with Molina)

**Habilitative Services**
Medically Necessary We cover 35 visits per year for habilitative services and devices are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Rehabilitative Services**
We cover Medically Necessary rehabilitative services. 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. This benefit includes visits with a chiropractor. The chiropractor must provide services in connection with outpatient rehabilitation, occupational therapy and physical therapy.

**Outpatient Mental/Behavioral Health Services**
We cover the following outpatient mental health service 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 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:

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 below.

**OUTPATIENT AUTISM SPECTRUM DISORDER SERVICES**
We cover treatment and services to Members under the age of 10 for all generally recognized services prescribed in relation to autism spectrum disorder by the Member’s PCP in the treatment plan recommended by that physician. These services include, but are not limited to:

- evaluation and assessment services;
- screening at ages 18 months and 24 months;
- applied behavior analysis as defined in Texas insurance regulations;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or

- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

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.

After the Member reaches age ten, the Benefits and Coverage as otherwise available under this Agreement will be available to the Member. All provisions of this Agreement will apply including, but not limited to, defined terms, limitations and exclusions, Prior Authorization and any applicable benefit maximums.

**OUTPATIENT SUBSTANCE ABUSE/CHEMICAL DEPENDENCY SERVICES**
We cover the following outpatient care for treatment of substance abuse/chemical dependency:

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

We cover substance abuse/chemical dependency under this policy. We do not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Outpatient Substance Abuse/Chemical Dependency Services" section.

**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. Services are limited to treatment provided within 24 months of the initial treatment. An injury as the result of biting or chewing shall not be considered an accidental injury.

**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 under age 7, or You are developmentally disabled, or Your health is compromised
    - The dental procedure must be provided in a hospital or outpatient surgery center because of clinical status or existing medical condition
- 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.

**PEDIATRIC VISION SERVICES**

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

- Routine vision screening and eye exam every calendar year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months.
- Covered frames include a limited selection of 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. Summary 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:

- Health management and counseling to help You make informed choices
- Health management and counseling to help You understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera
- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD’s)
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Pregnancy testing and counseling
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Screening, testing and counseling of at-risk individuals for HIV, and referral for treatment

**PREGNANCY TERMINATIONS**
Molina Healthcare only covers pregnancy termination services in the following instances:

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

Pregnancy termination services are office-based procedures and do not require Prior Authorization.

If pregnancy termination services will be provided in an inpatient setting or outpatient hospital, Prior Authorization is required. Office Visit and Outpatient Surgery Cost Sharing will apply.

**Keep in mind that some hospitals and providers may not provide pregnancy termination services.**
**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 (PKU) and other inborn errors of metabolism**
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. 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 Imaging and Scanning Services**
We cover Medically Necessary specialized scanning services. They include CT Scan, PET Scan, cardiac imaging, and MRI by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services.

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

**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. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider, unless Medically Necessary Prior Authorized service.

**Chemotherapy**
We cover chemotherapy when furnished by Participating Providers and Medically Necessary. Chemotherapy is subject to 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:

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

Members are responsible for 100% of charges for services furnished by a Non-Participating Provider, unless Medically Necessary Prior Authorized service.

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

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

# INPATIENT HOSPITAL SERVICES

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

**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:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialist physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to “Prescription Drugs and Medications” in this “What is Covered Under My Plan?” section)
- Biologicals, fluids and chemotherapy
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections (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
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge 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 need to be Authorized by 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, then at least 3 home care visits will be provided. You and Your physician may agree that 1 or 2 visits are sufficient. Home 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. 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 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. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"**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:

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

We cover for substance abuse/chemical dependency under this policy.

**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. Coverage for substance abuse/chemical dependency under this policy is limited to three separate series of treatment for each covered individual.

**Skilled Nursing Facility**

We cover skilled nursing facility (SNF) services when Medically Necessary and referred by Your PCP. Covered SNF services include:

- Room and boardPhysician and nursing services
- Medications
- Injections

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

The SNF benefit is limited to 25 days per calendar year.

**Hospice Care**

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

- Home hospice services
- A semi-private room in a hospice facility
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services for outpatient care
- Physician services
- Medication
- Medical supplies and appliances
- 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
- Counseling services for You and Your family
- Development of a care plan for You
- Short term inpatient care
- Pain control
- Symptom management

- Physical therapy, occupational therapy, and speech-language therapy. 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.

The hospice benefit is for people who are diagnosed with a terminal illness. Terminal illness means a life expectancy of 12 months or less. 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. Qualifying Members are those participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You must:

- Be enrolled in this product
- Be diagnosed with cancer or other 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

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial. These trials are conducted in relation to the prevention, detection, or treatment of cancer. They may also be conducted for other life-threatening disease or condition. In addition:

- The study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy; or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

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 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. Summary 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, subject to applicable Cost Sharing under the following conditions:

- They are ordered by a Participating Provider treating You and the drug is listed in the Molina Healthcare Drug Formulary. Drugs approved by Molina's Pharmacy Department are also covered.
- 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. They must be ordered by a Participating Provider in connection with a Covered Service. The prescription drugs are obtained through a pharmacy that is in the Molina pharmacy network.
- The drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

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

We cover these types of drugs when they are on the Drug Formulary. We cover these types of drugs when obtained through Molina's Participating Provider pharmacies within the 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 or Urgent Care Services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 560-2025 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 735-2989. 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.molinahealthcare.com/marketplace.

**Molina Healthcare Drug Formulary (List of Drugs)**

Molina Healthcare has a list of drugs that it will cover. The list is called 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 three months to talk about the drugs that are in the formulary. They review new drugs and changes in health care. They try to find the most effective drugs for different conditions. Drugs are added or removed from the Drug Formulary for different reasons. This could be:

- Changes in medical practice
- Medical technology
- When new drugs come on the market.

You can look at Our Drug Formulary on Our Molina Healthcare website. The address is www.molinahealthcare.com/marketplace. 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.

**Access to Drugs Which are Not Covered**

Molina has a process to allow You to request clinically appropriate drugs that are not covered under Your product. Your doctor may order a drug that is not in the Drug Formulary that he or she believes is best for You. Your doctor may contact Molina's Pharmacy Department to request that Molina cover the drug for You. If the request is approved, Molina will contact Your doctor. If the request is denied, Molina Healthcare will send a letter to You and Your doctor. The letter will explain why the drug was denied.

You may be taking a drug that is no longer on Our Drug Formulary. Your doctor can ask Us to keep covering it by sending Us a Prior Authorization request for the drug. The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You. Molina may cover specific non-Drug Formulary drugs under the following conditions:

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

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

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

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

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

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

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

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.

**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 unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, not subject to Cost Sharing. Your Cost Sharing for a covered drug will not be more than the price that We have negotiated to pay for the drug, or the usual and customary cost of the drug.

**Tier 1 - Formulary Generic Drugs**
Formulary Generic drugs are those drugs listed in the Molina Healthcare Drug Formulary that have the same ingredients as brand name drugs. To be FDA (government) approved the Formulary Generic drug must have the same active ingredient, strength, and dosage (formulation) as the brand name drug. Companies making a generic drug have to prove to the FDA that the drug works just as well and is as safe as the brand name drug. Cost Sharing for Formulary Generic drugs is listed on the Molina Healthcare of Texas, Inc. Schedule of Benefits. You will be charged a Copayment for Formulary Generic Drugs.

If Your doctor orders a brand name drug that is not in the Drug Formulary and there is a Formulary Generic drug available, we will cover the generic medication.

If Your doctor says that You must have the brand name drug that is not in the Drug Formulary instead of the generic, he/she must submit a Prior Authorization request to Molina Healthcare's Pharmacy department.

- If Prior Authorization is not obtained from Molina, You may purchase the brand name drug at the full cost charged by the pharmacy.
- If Prior Authorization is obtained from Molina, You may purchase the brand name drug at the following Cost Sharing:
    - The Cost Sharing for Formulary Non-Preferred Brand Name drugs listed on the Molina Healthcare of Texas, Inc. Benefits and Coverage Guide, plus
    - The difference in cost between the generic drug and brand name drug.

**Tier 2- Formulary Preferred Brand Name Drugs**
Formulary Preferred Brand Name drugs are those drugs listed which, due to clinical effectiveness and cost differences, are designated as "Preferred" in the Molina Healthcare Drug Formulary. Formulary Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and Our pharmacy benefit manager. Cost Sharing for Formulary Preferred Brand Name drugs is listed on the Molina Healthcare of Texas, Inc. Schedule of Benefits. You will be charged a Copayment for Formulary Preferred Brand Name Drugs.

**Tier 3- Formulary Non-Preferred Brand Name Drugs**
Formulary Non-Preferred Brand Name drugs are those drugs listed in the Molina Healthcare Drug Formulary, which are designated as "Non-Preferred" due to lesser clinical effectiveness and cost differences. Formulary Non-Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and Our pharmacy benefit manager. Cost Sharing for Formulary Non-Preferred Brand Name drugs is listed on the Molina Healthcare of Texas, Inc. Schedule of Benefits. You will be charged a Percentage of Cost SharingPercentage of Cost Sharing for Formulary Non-Preferred Brand Name Drugs.

**Tier 4 - Specialty Oral and Injectable Drugs**
Specialty drugs are prescription legend drugs within the Molina Healthcare Drug Formulary which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies.

Molina Healthcare may require that Specialty drugs be obtained from a participating specialty pharmacy or facility for coverage. Molina Healthcare's specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office. You will be charged a Percentage of Cost SharingPercentage of Cost Sharing for Specialty Oral and Injectable Drugs.

**Tier 5 - Formulary Preventive Drugs**
Formulary Preventive drugs are drugs listed in the Molina Healthcare Drug Formulary which are considered to be used for preventive purposes, including all methods of birth control approved by the FDA, or if it is 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. Cost Sharing for Formulary Preventive drugs are listed on the Molina Healthcare of Texas, Inc. Schedule of Benefits and are offered at No Charge.

**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.

**Stop-Smoking Drugs**
Stop-Smoking drugs are prescription drugs within the Molina Healthcare Drug Formulary that we cover to help You stop smoking. You can learn more about Your choices 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. You will also be given a phone number that You can call anytime You need help.

**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 is a 90- day supply applied at two times Your appropriate Copayment or Percentage of Cost SharingPercentage of Cost Sharing Cost Share based on Your drug tier for one month.

You may request mail order service in the following ways:

- You can order online. Visit www.molinahealthcare.com/marketplace 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.molinahealthcare.com/marketplace and select the mail order form option. Complete and mail the form to the address on the form along with Your payment. You can give Your doctor's office the toll-free FastStart® 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.

**Diabetes Supplies**

Diabetes supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, glucagon emergency kits, blood glucose test strips and urine test strips are covered supplies and are provided at Percentage of Cost SharingPercentage of Cost Sharing to You. Pen delivery systems for the administration of insulin are also covered and are provided at the Formulary Preferred Brand Cost Sharing amount found in the Molina Healthcare of Texas, Inc. Benefits and Coverage Guide section of this EOC.

**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 Authorized.

## ANCILLARY SERVICES

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

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

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

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

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

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

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. Benefits and Coverage Guide to see the Cost Sharing applicable to these devices.

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

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months when required to hold a prosthesis.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external 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, referred by Your PCP, and approved by Molina Healthcare:

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

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 up to four hours per visit by a home health aide
- Up to 60 visits per calendar year (counting all home health visits)

You must have Prior Authorization for all home health services before obtaining services.
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 transportation (ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary.

## HEARING SERVICES

We cover $1,000 per every 3 years for hearing aids. We also cover internally implanted devices as described in the "Prosthetic and Orthotic Devices" section.

We do cover the following:

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

## OTHER SERVICES

**Dialysis Services**
We cover acute and chronic dialysis services if all of the following requirements are met:
- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina 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 Urgent Care Services and Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United States. If You need Urgent Care Services while traveling outside the United States or outside the Service Area, go to Your nearest urgent care center or emergency room. If You require Emergency Services while traveling outside the United States, please use that country's or territory's emergency telephone number or go to the nearest emergency room.

If You receive health care services while traveling outside the United States 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 calculate the allowed amount that will be covered for Urgent Care Services and Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws. Because these services are performed by a Non-Participating Provider You will only be reimbursed for the allowed amount, 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, or Percentage of Cost Sharing cost share 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.

**Chiropractic Services**
Chiropractic services and the services of a chiropractor, except as described in the REHABILITATIVE SERVICES benefit.

**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.

**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 Medical Review” section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

**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. example Examples of these types of services are:

- Teaching manners and etiquette

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

**Items and Services to Correct Refractive Defects of the Eye**
Items and services (such as eye surgery or contact lenses to reshape the eye) 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.

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.

**Private Duty Nursing Services**

We do not cover private duty nursing services.

**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 which are not Medically Necessary (for example, Medically Necessary for the treatment of 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 Medical Review for Denials of Experimental/Investigational Therapies” section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

**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. For example, if You have a non-covered 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.

**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.

**Transgender Surgery**
We do not cover services and procedures for sexual transformation, including transsexual surgery or hormonal therapy in preparation for, or subsequent to, any such surgery.

**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 Urgent Care Services or 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, Deductibles, Copayments and Benefits and Coverage:**
Annual changes to Premium are effective after 60 days' notice to the Subscriber's address of record with Molina. Changes in Benefits and Coverage or Covered Services, Deductible, Copayment, Percentage of Cost Sharing and Annual Out-of-Pocket Maximum amounts require Molina to withdraw this product from the market with at least 90 days' notice to You, as described below under "Withdrawal of Product."

**When Will My Molina Healthcare Membership End?**
(Termination of Benefits and Coverage)
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, 2016, Your last minute of coverage was at 11:59 p.m. on June 30, 2016). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or deception in the use of services or facilities, Molina 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 in Molina Healthcare's Service Area for this product. The Marketplace will send You notice of any eligibility determination. Molina Healthcare will send You notice when it learns You have moved out of the Service Area. 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 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 Molina Healthcare and/or the Marketplace. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. Molina 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, in which case a notice of termination. 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 plan contracts, in which case Molina Healthcare will provide You with written notice at least 180 days prior to discontinuation of those contracts.
- **Withdrawal of Product:** Molina Healthcare withdraws this product from the market, in which case Molina Healthcare will provide You with written notice at least 90 days before the termination date. 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 Benefits and Coverage will terminate if Your eligibility for such benefits end. If only certain Benefits and Coverage 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. <u>If You do not pay the full Premium payment by the end of the grace period, this Agreement will be terminated.</u> 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 for Nonpayment of Premiums

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

- If Molina Healthcare terminates this Agreement for nonpayment of Premiums, we will permit reinstatement of this Agreement once during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice, described below. Molina Healthcare will not reinstate this Agreement if You do not obtain reinstatement of Your terminated Agreement within the required 15 days, or if we terminate the Agreement for nonpayment of Premiums more than once in a 12-month period. In either case, You will be ineligible to re-enroll for a period of 12 months from the effective date of termination.

**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. Summary 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 exception is in the case of Emergency or out of area Urgent Care Services.

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 policy 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 or Urgent Care Services from a no-Participating Provider.
With the exception of any required Cost Sharing amounts (such as a Copayment or Percentage of Cost Sharing), 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.

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 policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans 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 through a variable deductible.

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 deductibles, Percentage of Cost Sharing, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a 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 deductible, copayment, or Percentage of Cost Sharing 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 policy 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 deductible any amounts it would have credited to its deductible 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
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# 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

**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 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).

**Complaint**s -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 Benefit Determination constitutes an appeal of that Adverse Benefit Determination. Appeals of Adverse Benefit 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 Benefit Determinations**

An **"Adverse Benefit 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. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non—payment of premium.

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 has a life-threatening condition.
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.

You may request an Appeal of an Adverse Benefit Determination

## APPEAL PROCEDURES FOR ADVERSE BENEFIT 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.

Upon receipt of an expedited Prior Authorization or concurrent clinical appeal, Molina Healthcare will notify the party filing the appeal as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the 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.

### How to Appeal an Adverse Benefit Determination

An appeal of an Adverse Benefit 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 Benefit 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 Benefit 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 Benefit 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 Benefit 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 the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a physician associated or contracted with Molina Healthcare and/or by external advisors, but who were not involved in making the initial denial of Your claim. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal, and the appeal must be finally decided by Molina Healthcare.

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 Benefit Determination made by Molina Healthcare.

This procedure is not part of the complaint process and pertains only to appeals of Adverse Benefit 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.

For more information about the IRO process, call Texas Department of Insurance (TDI) on the IRO information line at (888) TDI-2IRO (834-2476).

## VOLUNTARY ARBITRATION:

## IF MEMBER AGREES TO THE VOLUNTARY OPTION TO RESOLVE DISPUTES BY ARBITRATION. MEMBERS PURSUING PERSONAL INJURY AND MEDICAL MALPRACTICE CLAIMS MUST FILE SUCH CLAIMS IN A COURT OF LAW.

*** *Important Information About Your Rights* ***

Any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this product, which may include but are not limited to claims of malpractice (e.g., in the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the healthcare provider) or claims that the medical services rendered under the product were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, between Member (including any heirs, successors or assigns of the Member) and Molina Healthcare, or any of its parents, subsidiaries, affiliates, successors or assigns may be submitted to binding arbitration in accordance with applicable state and federal laws including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, the Affordable Care Act, and the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code, Ch. 171, Section 171.001 *et seq.*) Any such dispute submitted to binding arbitration will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

Member and Molina Healthcare acknowledge that, by voluntarily agreeing to arbitrate, they will waive the right to trial by jury or to participate in a class action. Member and Molina Healthcare will give up their constitutional rights to have any such dispute decided in a court of law before a jury. If a Member agrees to submit a dispute to binding arbitration, Member further agrees to the following:

- The final and binding arbitration shall be conducted in accordance with the Comprehensive Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

- The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days from the date the notice of commencement of the arbitration is received, the arbitrator appointment procedures in the JAMS Comprehensive Rules and Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

- Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration in accordance with the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code, Ch. 171, Section 171.001 *et seq.*). The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Texas state law court, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

  The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. Proceeding with binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.
- The parties shall divide equally the costs and expenses of JAMS and the arbitrator. In cases of extreme hardship, Molina Healthcare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The hardship application shall be made in a manner and with the information and any documentation as required by JAMS. JAMS (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

- Member acknowledges that care, diagnosis and treatment will be provided whether or not the Member agrees to binding arbitration.

**IN PROCEEDING WITH ARBITRATION, THE PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED**

**BEFORE A JURY AND INSTEAD ACCEPT THE USE OF BINDING ARBITRATION.**

## 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 Policy by Molina that is effective prior to the change in marital status. The new policy will be issued without evidence of insurability in accordance with State Law and will have the same effective date as the policy 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 Benefits and Coverage 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 Benefits and Coverage 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. 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 or binding arbitration, 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 notifying Us of any change in address.

## HEALTH EDUCATION AND HEALTH MANAGEMENT LEVEL 1 PROGRAMS

The tools and services described here are educational support for Our Members. We may change them at any time as necessary to meet the needs of Our Members.

**Health Management**
Molina Healthcare offers programs to help keep You and Your family healthy. You may ask for booklets on topics such as:

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

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

**Motherhood Matters®**
*A Prenatal Care Program for Pregnant Women*

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

Motherhood Matters® is a program for pregnant women. This program will help women get the education and services they need for a healthy pregnancy. You will be mailed a pregnancy book that You can use as a reference throughout Your pregnancy.
You will be able to talk with Our caring staff about any questions You may have during Your pregnancy. They will teach You what You need to do. If any problems are found, a nurse will work closely with You and Your doctor to help You. Being a part of this program and following the guidelines will help You have a healthy pregnancy and a healthy baby.

*Your Baby's Good Health Begins When You Are Pregnant*
You Learn:

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

Other benefits include

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

To find out more about the Motherhood Matters® program, call the Molina Health Management Department at 1 (866) 891-2320 between 10:30 a.m. and 7:30 p.m. (CDT), Monday through Fiday.
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## HEALTH MANAGEMENT LEVEL 1 PROGRAMS

Molina's Health Management Level 1 Programs Department is committed to helping You stay well. Find out if You are eligible to sign up for one of Our programs.

Call toll-free:
**1 (866) 472-9483**
9:30 a.m. and 6:30 p.m. MT,
Monday through Friday.

Ask about other services We provide or request information to be mailed to You.

**Smoking Cessation Program**
This program offers smoking cessation services to all smokers interested in quitting the habit. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support.

**Weight Control Program**
This program is for Members who need help controlling their weight.

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

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.

## 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.

Percentage of Cost Sharing and 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.

[Note to Reviewer: In the event that CA-125 is required it will be included in the EOC; to the extent the test is not required it would not be included.]

## 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.<br><br>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 10:30 a.m. and 7:30 p.m. (CDT) Monday through Friday |
| Health Management Level 1 Programs | To request information on smoking cessation and weight management. | 1 (866) 472-9483 between 10:30 a.m. and 7:30 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 |
| Motherhood Matters® | Molina Healthcare offers a special program called Motherhood Matters® to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy. | 1 (866) 891-2320 between 10:30 a.m. and 7:30 p.m. (CDT)Monday through Friday |
| Secretary of the U.S. Department of Health and Human Services Office for Civil Rights | If You believe that we have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance). | (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.**