Molina Healthcare of Utah, Inc. Marketplace

2023

Agreement and Individual Evidence of Coverage

Molina Healthcare of Utah, Inc.
7050 Union Park Center, Suite 200
Midvale, Utah 84047

MHU01012023

Molina Healthcare of Utah, Inc. is domiciled in the State of Utah

MOLINA REFERENCE GUIDE

Service	Need	Where to Go
Emergency Services	• Treatment of an Emergency Medical Condition	**Call 911**, or go to any Emergency room, even if it is a Non-Participating Provider or outside of the Service Area.

Getting Care	• Urgent Care
	  ○ Minor Illnesses
	  ○ Minor Injuries
		Urgent Care Centers
		Find a Provider or Urgent Care center
		MolinaMarketplace.com

	• Virtual Care	**Virtual Care** www.teladoc.com/molinaMarketplace 1-800-TELADOC
	• Healthcare advice 24 hours a day, 365 days a year.	**24-Hour Nurse Advice Line** 1 (888) 275-8750 (English) 1 (866) 648-3537 (Spanish)
Online Access	• Find or change a doctor • View benefits and Member Handbook • View or print ID card Track claims	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaMarketplace.com
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card support • Help with your visits • Payment Questions	**Molina Customer Support Center** **(888) 858-3973** Monday through Friday, 8:00 a.m. to 6:00 p.m. **Go to** MyMolina.com **Go to** MolinaPayment.com
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report change of address or income	**Go to** Healthcare.gov 1 (800) 318-2596

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Right to Return: Newly enrolled Subscribers have the right to return this Agreement until midnight of the tenth day after the date on which the Subscriber receives the Agreement, by returning the Agreement to Molina or an agent of Molina. No reason need be stated for the return. Molina will treat this Agreement as if it had never been issued and will return all premium payments to the Subscriber. If the Subscriber returns this Agreement under this provision, they will be responsible for payment of any healthcare service they or a Dependent received before they returned the Agreement.

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

Incorporation by Reference: This Agreement, amendments, riders to this Agreement, the applicable Schedule of Benefits for this Plan, and any application(s) submitted to the Marketplace and/or Molina to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the entire legally binding contract between Molina and the Subscriber.

Contract Changes: No amendment, modification or other change to this entire legally binding contract between Molina and the Subscriber shall be valid until approved by Molina and evidenced by a written document signed by an executive officer. No agent of Molina has authority to change this Agreement and incorporated documents or to waive any of its provisions.

Interpreter Services: Molina offers interpreter services for any Member who may need language assistance to understand and obtain health coverage information under this Agreement. Molina provides these services at no additional cost to the Member. Molina will provide oral interpretation services and written translation services for any materials vital to a Member understanding their health care coverage. Members who are deaf or hard of hearing can use the Telecommunications Relay Service by dialing 7-1-1.

Renewability of Coverage: Molina will renew coverage for Members on the first day of each month if all Premiums which are due have been received. Renewal is subject to Molina's right to amend this Agreement and the Member's continued eligibility for this Plan. Members must follow all procedures required by the Marketplace to redetermine eligibility and guaranteed renewability for enrollment every year during the Open Enrollment Period.

Time Zone: Except as otherwise expressly provided herein, all references to a specific time of day refer to the specific time of day in the Mountain time zone of the United States of America

Thank You for Choosing Molina!

As an organization that's been taking care of kids, adults, and families for over 40 years, Molina is excited to be your Plan.

We're sending you this 2023 Molina Healthcare of Utah, Inc. Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

- How you can get Covered Services through Molina
    - Getting an interpreter
    - Choosing a Primary Care Provider (PCP)
    - Making an appointment
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Molina Member
    - Checking on Prior Authorization status
- How to contact Molina

Please read this Agreement carefully. Inside is information about a wide range of health needs and services provided. For questions or concerns, please reach out to Customer Support at MolinaMarketplace.com or (888) 858-3973.

We look forward to serving you!

DEFINITIONS

Some of the words or terms used in this Agreement do not have their usual meaning. Health plans use these words in a special way. When a word with a special meaning is used in only one section of this Agreement, it is explained in that section. Words with special meaning used in any section of this Agreement are capitalized and are explained in this Definitions section.

Adverse Benefit Determination: A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including those based on a determination of eligibility, application of utilization review or Medical Necessity. This can include rescission of coverage.

Affordable Care Act: The comprehensive health care reform law enacted in March 2010 (sometimes known as "ACA," "PPACA," or "Obamacare")

Allowed Amount: The maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing. As applicable:

1. For Covered Services furnished by a Participating Provider: These services shall be reimbursed at the contracted rate with the Participating Provider for such Covered Services.

2. For certain Covered Services furnished by a Non-Participating Provider: Subject to exceptions expressly permitted by law, the services described below shall be reimbursed at the out-of-network rate, as that term is defined and determined under applicable federal law:

- Emergency Services furnished by a Non-Participating Provider
- Post-Stabilization Services furnished by a Non-Participating Provider when such Covered Services are treated, for reimbursement purposes, as Emergency Services under applicable State Law or federal law
- Air ambulance services furnished by a Non-Participating Provider; and
- Covered Services furnished by a Non-Participating Provider during a visit at a Participating Provider that is a hospital, critical access hospital, ambulatory surgical center, or other facility required by law.

In the case of exceptions expressly permitted by law, the Allowed Amount shall be determined in accordance with the procedures (including dispute resolution proceedings) or other requirements dictated by applicable state law, when federal law defers to state law in determining reimbursement amounts to Non-Participating Providers, or federal law, when federal law controls the reimbursement amount to Non-Participating Providers.

3. For all other Covered Services furnished by a Non-Participating Provider in accordance with this Agreement: Except if otherwise expressly required by applicable law, these services shall be reimbursed at the lowest of (a) Molina's median contracted rate for such Covered Service(s), (b) 100% of the published Medicare rate for such Covered Service(s), (c) Molina's usual and customary method for determining payment for such Covered Service(s), or (d) a negotiated

amount agreed to by the Non-Participating Provider and Molina.

Annual Out-of-Pocket Maximum (also referred to as "OOPM"): The most a Member must pay for Covered Services in a Plan year. After a Member spends this amount on Deductibles, Copayments, and Coinsurance, Molina pays 100% of the costs of Covered Services. The amounts the Subscriber or Dependents pay for services not covered by this Plan do not count towards the OOPM. The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1.The individual OOPM will be met, with respect to the Member, when that person meets the individual OOPM amount; or

2. The family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Member adds up to the individual OOPM amount, Molina will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year if they remain enrolled in this Plan. Once the Cost Sharing for two or more Member's family adds up to the family OOPM amount, Molina will pay 100% of the charges for Covered Services for the rest of the calendar year for the Member and every Member of their family if they remain enrolled in this Plan.

Balance Bill or Balance Billing: When a Provider bills a Member for the difference between the Provider's charged amount and the Allowed Amount. A Molina Participating Provider may not Balance Bill a Member for Covered Services.

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

Coinsurance: A percentage of the charges for Covered Services the Member must pay when they receive certain Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. If applicable, Coinsurances are listed in the Schedule of Benefits.

Copayment: A fixed amount the Member will pay for a Covered Service. If applicable, Copayments are listed in the Schedule of Benefits.

Cost Sharing: The share of costs that a Member will pay out of their own pocket for Covered Services. This term generally includes Deductibles, Coinsurance, and Copayments, but it doesn't include Premiums, Balance Bill amounts from Non-Participating Providers, or the cost of non-Covered Services. Where required for Covered Services captured under the federal No Surprises Act, this amount will be calculated based on the Recognized Amount.

Covered Service or Covered Services: Medically Necessary services, including some medical supplies, Durable Medical Equipment, and prescription drugs, that Members are eligible to receive from Molina under this Plan.

Deductible: The amount Members must pay for Covered Services before Molina begins to pay for Covered Services. Please refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan.

Dependent: A Member who meets the eligibility requirements as a Dependent, as described in this Agreement.

Drug Formulary or Formulary: A list of drugs this Molina Plan covers. The Drug Formulary also puts drugs in different Cost Sharing levels or tiers.

Durable Medical Equipment or DME: Equipment and supplies ordered by a Provider for everyday or extended use. Examples of DME may include Medically Necessary oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency medical condition means that there is inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or child.

Emergency Services: Services to evaluate, treat or stabilize an Emergency Medical Condition. These services may be provided in a licensed emergency room or other facility that provides treatment of Emergency Medical Conditions.

Emergency Transportation Services: Appropriate ambulance transfers undertaken prior to an Emergency Medical Condition being stabilized.

Essential Health Benefits or EHB: A set of ten (10) categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient Hospital care, prescription drug coverage, pregnancy and childbirth, Mental Health Services, and more.

Experimental or Investigational: Any medical service including procedures, medications, facilities, and devices that the FDA has not approved for treatment or therapeutic use in connection with the underlying medical condition for which such procedure, medication, facility or device was prescribed.

FDA: The United States Food and Drug Administration.

Hospital: A legally operated facility licensed by the State, the principal purpose or function of which is providing of medical or Hospital care or medical education or medical research.

Marketplace: A governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State buy qualified health plan coverage from companies or health plans such as Molina. The Marketplace may be run as a state-based Marketplace, a federally facilitated Marketplace, or a partnership Marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State, however it may be organized and run.

Medical Necessity or Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Member: An individual who is eligible and enrolled under this Agreement, and for whom Molina has received applicable first Premium payment (binder). The term includes a Dependent and a Subscriber, unless the Subscriber is 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 but will not be a Member.

Mental Health Services: Medically Necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association and any associated State or federal laws.

Molina Healthcare of Utah Inc. ("Molina"): The corporation authorized in Utah as a health maintenance organization and contracted with the Marketplace.

Molina Healthcare of Utah, Inc. Agreement and Individual Evidence of Coverage: This document, which has information about coverage under this Plan. It is also called the "Agreement".

Non-Participating Provider: A Provider that has not entered into a contract with Molina to provide Covered Services to Members.

Other Practitioner: Participating Providers who provide Covered Services to Members within the scope of their license but are not Primary Care Providers or Specialists.

Out-of-Area Service: A service that is provided outside of the Service Area and is therefore not a Covered Service, except as otherwise stated in this Agreement.

Participating Provider: A Provider that furnishes any health care services and is licensed or otherwise authorized to furnish such services and contracts with Molina and has agreed to provide Covered Services to Members.

Plan: Health insurance coverage issued to an individual and Dependents, if applicable, that provides benefits for Covered Services. Depending on the services, Member Cost Sharing may apply.

Post-Stabilization Services: Items and services that are furnished (regardless of the department of the hospital where that occurs) after the Member is stabilized and as part of out-patient observation or an inpatient or out-patient stay with respect to the visit in which Emergency Services are furnished.

Primary Care Provider: A Provider who has identified their primary professional designation to Molina as a Primary Care Provider. A PCP can be a physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), certified nurse practitioner, clinical nurse specialist, or Physician Assistant, as allowed under State Law and the terms of the Plan, who provides, coordinates, or helps a Member access a range of health care services.

Prior Authorization: Approval from Molina that is needed before Members get a medical service or drug so that the service or drug is covered.

Provider: Any health professional, Hospital, other institution, organization, pharmacy, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

Recognized Amount: Where required by the federal No Surprises Act, means the amount on which Member Cost Sharing amounts are calculated for Covered Services that are captured under the federal No Surprises Act.

Schedule of Benefits: A comprehensive listing of Covered Services and applicable Member Cost Sharing.

Service Area: The geographic area where Molina has been authorized by the State 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: A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Stabilize: To provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman who is having contractions, to deliver (including the placenta).

State Law: The body of law in Utah. It consists of the state's constitution, statutes, regulations, sub-regulatory guidance, state regulatory agency directives and common law.

Urgent Care or Urgent Care Services: Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency room care.

ENROLLMENT AND ELIGIBILITY

An individual must be enrolled as a Member of this Plan for Covered Services to be available. To enroll and become a Member of this Plan, an individual must meet all eligibility requirements established by the Marketplace. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber for this Plan.

Open Enrollment Period: The Marketplace will set a yearly period in which eligible individuals can apply and enroll in a health insurance plan for the following year. The effective date of coverage will be January 1st, or a date determined by the Marketplace.

Special Enrollment Period: If an individual does not enroll during an Open Enrollment Period, they may be able to enroll during a Special Enrollment Period. To qualify for a Special Enrollment Period, an individual must have had certain life events established by the Marketplace. The Effective Date of a Member's coverage will be determined by the Marketplace. For more information about Open Enrollment and Special Enrollment Periods, please visit: Healthcare.gov

Child-Only Coverage: Molina offers Child-Only Coverage for individuals who, as of the beginning of the Plan year, have not attained the age of 21. A parent or legal guardian must apply for Child-Only Coverage on behalf of the individual under the age of eighteen (18). For more information regarding eligibility and enrollment, please contact the Health Benefit Exchange.

Dependents: Subscribers who enroll during the Open Enrollment Period established by the Marketplace may also apply to enroll eligible individuals as Dependents as established by the Marketplace. Dependents must meet the eligibility requirements as established by the Marketplace. Dependents must live in the Service Area for this Plan and are subject to the terms and conditions of this Agreement. The following family Members are individuals considered Dependents:

- **Spouse:** The individual lawfully married to the Subscriber under State Law.

- **Child or Children:** The Subscriber's son, daughter, adopted child, stepchild, foster child or a descendent of any of them such as a Member's grandchild. Each child is eligible to apply for enrollment as a Dependent until the age of twenty-six (26).

- **Dependent with a Disability:** A child who reaches the age of twenty-six (26) is eligible to continue enrollment if the child meets the following eligibility criteria established by State Law:
  - Unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment, as defined by State Law, which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and
  - Chiefly dependent upon an insured for support and maintenance

- **Domestic Partner:** An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but isn't married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace, Molina, and State Law.

Adding New Dependents: An individual may become eligible to be a Dependent after the Subscriber becomes enrolled in this Plan. The eligible individual may be able to enroll as a Dependent in the Member's Plan. Members must contact the Marketplace and submit any required applications, forms and requested information for the Dependent. A Member's request to enroll a new Dependent must be submitted to the Marketplace within 60 days from the date the Dependent became eligible to enroll in the Plan.

- **Spouse:** A Spouse may be added as a Dependent of the Subscriber applies no later than 60 days after any event listed below:
  - Loss of minimum essential coverage, as defined by the Affordable Care Act
  - The date of marriage to the Subscriber
  - The Spouse gains status as a citizen, national, or lawfully present individual
  - The Spouse permanently moves into the Service Area.

- **Children (Under 26 Years of Age):** Children may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
  - Loss of minimum essential coverage, as defined by the Affordable Care Act
  - Becomes a Dependent through marriage, birth, date of birth or placement for adoption, placement in foster care, child support, or other court order. An adopted child is provided coverage from the moment of birth or from the date of placement.
  - The Child gains status as a citizen, national, or lawfully present individual
  - The Child permanently moves into the Service Area.

- **Newborn Child:** A newborn child of a Subscriber is eligible as a Dependent at birth. A newborn is automatically covered for 60 days, including the date of birth. A newborn child is eligible to continue enrollment if they enrolled within Molina within 60 days.

Please note: Claims for newborn children for eligible Covered Services will be processed as part of the mother's claims and any Deductible or OOPM amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and OOPM. However, if an enrollment file is received for the newborn during the first thirty-one (31) days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Deductible or OOPM amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or OOPM (i.e., not under the enrolled mother's Deductible and OOPM).

Discontinuation of Dependent Coverage: Coverage for Dependent will be discontinued on:

- At 11:59 p.m. on the last day of the calendar year that the Dependent child attains age twenty-six (26), unless the child has a disability and meets specified criteria (see Child with a Disability).
- The date a final decree of divorce, annulment, or dissolution of marriage between the Subscriber and Dependent Spouse is entered.
- The date a termination of the domestic partnership decree between the Subscriber and Dependent Domestic Partner is entered.
- For Child-Only Coverage, at 11:59 p.m. on the last day of the calendar year in which the Child Member reaches the limiting age of 21. Any Dependent may be eligible to enroll in other products offered by Molina through the Marketplace.
- Date the Subscriber loses coverage under this Plan.

Continued Eligibility: If a Member is no longer eligible for coverage under this Plan, Molina will send a written notification at least thirty (30) days before the effective date on which the Member will lose eligibility. The Member can appeal the loss of eligibility with the Marketplace.

PREMIUM PAYMENT

To begin and maintain coverage under this Plan, Molina requires Members to make monthly payments in consideration, known as Premium Payments or Premiums. Premium Payment for the upcoming coverage month is due no later than the 25th day of that the current month (this is the "Due Date"). Molina will send a Subscriber written notification informing them of the amount due for coverage for the upcoming month in advance of the Due Date.

Advanced Premium Tax Credit (APTC): Advanced Premium Tax Credit is a tax credit a Subscriber can take in advance to lower their monthly Premium. Molina does not determine or provide tax credits, and Subscribers must contact the Marketplace to determine if they are eligible. If the Subscriber is eligible for an Advanced Premium Tax Credit, they can use any amount of the (APTC) in advance to lower their Premium.

Payment: Molina accepts Premium Payments online, by phone, by mail, and through money order. Please refer to MyMolina.com, MolinaPayment.com, or contact Customer Support for further information. Payments are not accepted at Molina office locations.

Late Payment Notice: Molina will send written notification to the Subscriber's address of record if full payment of the Premium is not received on or before the Due Date. This notification will inform the Subscriber of the amount owed, include a statement that Molina will terminate the Agreement for nonpayment if the full amount owed is not received prior to the expiration of the Grace Period as described in the Late Payment Notice, and provide the exact time when the Membership of the Subscriber and any enrolled Dependents will end if payment is not received timely.

Grace Period: A Grace Period is a period of time after a Member's Premium Payment is due and has not been paid in full. If a Subscriber hasn't made full Premium Payment,

they may do so during the Grace Period and avoid losing their coverage. The length of time for the Grace Period is determined by whether the Subscriber receives an APTC. If Premium payment is not received timely, Molina will send written notification to the Subscriber notice of non-receipt of payment and cancellation of coverage.

- **Grace Period for Subscribers with APTCs**: Molina will provide a Grace Period of three (3) consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, is receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for services in the second and third months of the Grace Period; Molina will terminate this Agreement as of 11:59 p.m. Mountain Time on the last day of the first month of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

- **Grace Period for Subscribers with No APTC:** Molina will provide a Grace Period of 15 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pend all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement on the last day of the month prior to the beginning of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

Termination Notification for Non-Payment: Molina will send written notification to a Subscriber informing them when their membership and the membership of their Dependents ended due to non-payment of Premiums. Members may appeal a termination decision by Molina. Please refer to MolinaMarketplace.com, the Complaints, Grievances and Appeals section of this Agreement, or contact Customer Support for more information of how to file an appeal.

Reinstatement after Termination: Molina will allow reinstatement of Members, without a break in coverage, provided the reinstatement is a correction of an erroneous termination or cancellation action and is permitted by the Marketplace.

Re-enrollment After Termination for Non-Payment: If a Subscriber is terminated for non-payment of Premium and enrolls with Molina during the Open Enrollment Period or a Special Enrollment Period in the following plan year, Molina may require that a Subscriber pay any past due Premiums. Molina will also require first month's Premium paid in full, before Molina accepts enrollment of the Subscriber. If a Subscriber pays all past due Premiums, eligible claims that were previously denied as a result of that nonpayment will be reprocessed for payment.

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not enrolled with Molina. Coverage for a former Member ends at 11:59 p.m. on the day before the termination

date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date. Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on account of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within thirty (30) days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina will refund all premiums collected minus claims that have been paid.

Molina may terminate or not renew a Member for any of the following reasons:

Dependent and Child-Only Ineligibility Due to Age: A Dependent no longer meets the eligibility requirements for coverage required by the Marketplace and Molina due to their age. Please refer to the "Discontinuation of Dependent Coverage" section for more information regarding when termination will be effective.

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by the Marketplace and Molina. The Marketplace will send the Member notification of loss of eligibility. Molina will also send the Member written notification when informed that the Member no longer resides within 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 the Member. The Member may request an earlier termination effective date.

Non-Payment of Premium: Please refer to "Premium Payment" section

Fraud or Intentional Misrepresentation: Member has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with coverage. Molina will send written notification of termination, and the Member's coverage will end at 11:59 p.m. on the 30th day from the date notification is sent. If the Member has committed fraud or intentional misrepresentation, Molina may not accept enrollment from the Member in the future and may report any suspected criminal acts to authorities.

Member Disenrollment Request: Member requests disenrollment to the Marketplace. The Marketplace will determine the coverage end date.

Discontinuation of a Particular Product: Molina decides to discontinue offering a product, in accordance with State Law. Molina will provide written notification of discontinuation at least ninety (90) calendar days before the date the coverage will be discontinued.

Discontinuation of All Coverage: Molina elects to discontinue offering all health insurance coverage in a State in accordance with State Law. Molina will send Members written notification of discontinuation at least one-hundred and eighty (180) calendar days prior to the date the coverage will be discontinued.

CONTINUITY OF CARE

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

An Active Course of Treatment is:

- An ongoing course of treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
- An ongoing course of treatment for a serious acute condition, which is a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy
- The second or third trimester of pregnancy through the postpartum period, or
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

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

- Upon successful transition of care to a Participating Provider if the Member chooses to transition their care.
- Upon completion of the course of treatment prior to the 90th day of continuity of care
- Upon completion of the 90th day of continuity of care
- The Member has met or exceeded the benefit limits under their plan
- Care is not Medically Necessary
- Care is excluded from a Member's coverage
- The Member becomes ineligible for coverage

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Molina's Allowed Amount or an agreed upon rate for such services. If Molina and the provider are unable to settle on an agreed upon rate, the Member may be responsible to the provider for any billed amounts that exceed Molina's Allowed Amount. That would be in addition to any in-network Cost Sharing amounts that Members owe under this Agreement. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Member's Deductible or OOPM.

Transition of Care: Molina may allow a new Member to continue receiving Covered Services for an ongoing course of treatment with a Non-Participating Provider until Molina arranges a transition of care to a Participating Provider, under the following conditions:

1. Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through the Prior

Authorization review process. Members may contact Molina to initiate Prior Authorization review.

2. Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina) may be responsible for coverage until a Member's coverage is effective with Molina.
3. After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider on a Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.
4. For Inpatient Services: With the Member's assistance, Molina may reach out to any prior insurer (if applicable) to determine the Member's prior Insurer's liability for payment of inpatient Hospital services through discharge of any Inpatient admission. If there is no transition of care provision through the Member's prior insurer or if a Member did not have coverage through an Insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of coverage with Molina, not prior.

ACCESS TO CARE

For an Emergency, call 911. For an Emergency, Members may call an Ambulance or go to any Hospital Emergency room, even if it is a Non-Participating Provider or outside of the Service Area.

24-Hour Nurse Advice Line: Registered Nurses are available twenty-four (24) hours a day, year-round to answer questions and help Members access care. The Nurse Advice Line phone number is (888) 275-8750.

Participating Provider Requirement: In general, a Member must receive Covered Services from a Participating Provider; otherwise, the services are not covered, the Member will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to the Deductible or OOPM. However, a Member may receive Covered Services from a Non-Participating Provider for the following:

- Emergency Services and Post-Stabilization Services
- Services from a Non-Participating Provider that are subject to Prior Authorization
- Exceptions described below under No Participating Provider to Provide a Covered Service
- Exceptions described under Continuity of Care section
- Exceptions described under Transition of Care section

To locate a Participating Provider, please refer to the provider directory at MolinaMarketplace.com or call Customer Support. Members may refer to MolinaMarketplace.com or contact Customer Support for additional information regarding protections from Balance Billing through Federal and State Law.

Member ID Card: Members should carry their Member identification (ID) card with them at all times. Members must show their ID card every time they receive Covered

Services. For a replacement ID card, visit MyMolina.com or contact Customer Support. Digital versions of the ID card are available through MyMolina.com and the Molina Mobile App.

Member Right to Obtain Healthcare Services Outside of Agreement: Molina does not restrict Members from freely contracting at any time to obtain any healthcare services outside this Agreement on any terms or conditions they may choose. Members will be 100% responsible for payment for such services and the payments for such services will not apply to their Deductible or OOPM under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement.

Primary Care Provider (PCP): A Primary Care Provider (or PCP) takes care of routine and basic health care needs. PCPs provide Members with services such as physical exams, immunizations, or treatment for an illness or injury that is not needed on an urgent or Emergency basis. Molina asks Members to select a PCP from the provider directory. If a PCP is not selected, one will be assigned by Molina.

Members can request to change their PCP at any time at MyMolina.com or by contacting Customer Support. Changes made by the 25th of the month will be in effect on the first day of the following calendar month. Changes made on or after the 26th of the month will be in effect on the first day of the second calendar month.

Each family Member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP. Sometimes a Member may not be able to get the PCP they want. This may happen because:

- The PCP is no longer a Participating Provider with Molina
- The PCP already has all the patients they can take care of right now

Telehealth Services: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. Covered Services are also available through Telehealth, except as specifically stated in this Agreement. In-person contact with a Provider is not required for these services, and the type of setting where these services are provided is not limited. The following additional provisions apply to the use of Telehealth services:

- Must be obtained from a Participating Provider
- Are meant to be used when care is needed now for non-Emergency medical issues
- Are a method of accessing Covered Services, and not a separate benefit
- Are not permitted when the Member and Participating Provider are in the same physical location
- Do not include texting, facsimile, or e-mail only

Covered Services provided through store and forward technology must include an in-person office visit to determine diagnosis or treatment.

No Participating Provider to Provide a Covered Service: If there is no Participating Provider that is able to provide a non-Emergency Medically Necessary Covered Service, Molina will provide the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the Covered Service when rendered by Participating Providers. Prior Authorization is required before the initiation of the service by the Non-Participating Provider.

Moral Objections: Some Participating Providers may object to provide some of the services that may be covered under this Agreement. This may include family planning, contraceptive drugs, devices and products approved by the FDA, including Emergency contraception, sterilization (including tubal ligation at the time of labor and delivery), pregnancy termination, assisted suicide, and other services. Members should contact their Participating Providers or Molina Customer Support to make sure they can get the healthcare services that they are seeking. Molina will assist Members to receive requested Covered Services rendered by other Participating Providers.

Accessing Care for Members with Disabilities: The Americans with Disabilities Act (ADA) prohibits discrimination based on disability. The ADA requires Molina and its contractors to make reasonable accommodations for Members with disabilities. Members with disabilities should contact Molina Customer Support to request reasonable accommodation assistance.

Physical Access: Every effort has been made to ensure that Molina's offices and the offices of Participating Providers are accessible to persons with disabilities. Members with special needs should call Molina's customer support center at the number shown on the Welcome page of this Agreement for assistance finding an appropriate Participating Provider.

Access for the Deaf or Hard of Hearing: Call Customer Support at the TTY 711 number for assistance.

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important Member materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available. This Agreement is also available in an audio format. For accessible formats, or for direct help in reading the Agreement and other materials, please call Customer Support.

Disability Access Grievances: If a Member believes Molina or it's Providers have failed to respond to their disability access needs, they may file a grievance with Molina. Please refer to the Complaints, Grievances, and Appeals section of this Agreement for information regarding how to file a grievance.

PRIOR AUTHORIZATION

Prior Authorization Process:

Molina must approve your use of some medical services and drugs before they will be covered. This approval is called Prior Authorization ("PA"). Members may receive many Covered Services without PA. If a medical service or drug needs PA, Member's Provider will seek PA for on their behalf.

Please view MolinaMarketplace.com/UTGetCare for a full list of Covered Services. The list shows which services do and do not need PA. Members may also call Customer Support.

Molina reviews a request for PA after receiving all needed information. Member's Provider may ask that Molina speed up the PA process if the request is urgent. Molina will tell the Member's Provider about the decision within the time allowed by State and Federal Law.

Members will be told if the request for PA is denied. If the PA is denied, Members will get information about how to appeal the denial.

PA rules may change. Members should contact Customer Support or visit MolinaMarketplace.com prior to receiving certain services.

PA Timeframes

Medical Services:

- **Routine PA Requests:**
  - 15 days.
  - Extension: 15 more days, if needed. Molina will provide notice of the reason for delay.
- **Urgent PA Requests**:
  - 72 hours from request.
  - Extension: If we need more information, Molina will request it. Molina will decide within 48 hours after we receive the information or after the deadline to submit the information, whichever is earlier.

The urgent timeframe applies if use of the standard timeframe:

- May seriously threaten your life or health.
- May seriously threaten your ability to regain full function.
- Would cause severe pain and cannot be managed without the requested care, according to your provider.

Emergency Medical Conditions and Post-Stabilization Services: Do not need PA.

Prescription Drugs and Medications: Prior Authorization decisions and notifications for medications not listed on the Molina Formulary will be provided as described in the section of this Agreement titled “Access to Non-Formulary Drugs.”

Medical Necessity: Prior Authorization determinations are made based on a review of Medical Necessity for the requested service. Molina is here to help Members throughout this process. If a Member has questions about how a certain service may be approved, they may visit MolinaMarketplace.com or contact Customer Support. Molina can explain how this Medical Necessity decisions are made.

Molina will not approve a Prior Authorization if information requested in connection with reviewing the Prior Authorization is not provided. If a service request is not Medically Necessary, it will not be approved. If the service requested is not a Covered Service, it will not be approved. Members will get a letter telling them why a Prior Authorization request was not approved. The Member, the Member’s Authorized Representative or their Provider may appeal the decision. The denial decision letter will inform Members of the process to appeal the denial decision. These instructions are in the section of this Agreement titled Complaints and Appeals.

If a Member or their Provider decides to proceed with a service that has not been approved, the Member will have to pay the cost of those services as non-covered services not covered by this Agreement.

Utilization Review: Licensed Molina staff processes Prior Authorization requests and conducts concurrent review. Upon request Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations. Molina provides assistance and informs Members of alternatives for care when a Member is not authorized for a service. Please contact Customer Support for utilization review questions.

Inpatient Concurrent Review: Molina conducts concurrent review on inpatient cases. For non-Emergency admissions, a Member, their Provider, or the admitting facility will need to request precertification at least fourteen (14) days before the date the Member is scheduled to be admitted. For an Emergency admission, a Member, their Provider, or the admitting facility should notify Molina within twenty-four (24) hours or as soon as reasonably possible after the Member has been admitted. For outpatient and inpatient non-Emergency medical services requiring Prior Authorization, a Member, their Provider, or the admitting facility must notify Molina at least fourteen (14) days before the outpatient care is provided, or the procedure is scheduled.

Second Opinion: A Member’s Provider may want another Provider to review a Member’s condition, which is called a Second Opinion. This Provider may review the Member’s medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

COORDINATION OF BENEFITS (COB)

This 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 accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% 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 and nongroup insurance contracts, Health Maintenance Organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2) Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by State Law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) 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 similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is

not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a 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 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
5) The amount of any benefit reduction by the Primary Plan because a 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, precertification of admissions, and preferred Provider arrangements.

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 Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

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

Order of Benefits Determination: When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

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

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

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

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been arried:
The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married: (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree; (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits; (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then

• The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

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

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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 non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right to Receive and Release Needed Information: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Molina may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Molina need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Molina any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Molina 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. If the amount of the payments made by Molina 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.

Right of Recovery: If the amount of the payments made by Molina is more than should have paid under this COB provision, Molina may recover the excess from one or more of the persons we paid or for whom we had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Molina may recover any amount improperly paid to a provider or Member:

1. In accordance with any provision of State Law or federal law
2. Within 24 months of the amount improperly paid for a coordination of benefits error
3. Within 12 months of the amount improperly paid for any other reason not identified above in (1) or (2) or
4. Within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program

COST SHARING

Molina requires Members to pay Cost Sharing for certain Covered Services under this Agreement. Members should review their Schedule of Benefits for all applicable Cost Sharing for Covered Services. For certain Covered Services, such as laboratory and X-rays that are provided on the same date of service and in the same location as an office visit to a PCP or a Specialist, Members will only be responsible for the applicable Cost Sharing amount for the office visit.

Members receiving covered inpatient Hospital or skilled nursing facility services on the effective date of this Agreement pay the Cost Sharing in effect for this Agreement upon the effective date of coverage with Molina. For items ordered in advance, Members pay the Cost Sharing in effect for this Agreement upon the effective date, for Covered Services only. For outpatient prescription drugs, the order date is the date the Participating Provider pharmacy processes the order after receiving all the information they need to fill the prescription.

Non-Participating Providers must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care from a Non-Participating Provider before that Non-Participating Provider can bill a the higher out-of-network rate.

COVERED SERVICES

This section describes the Covered Services available with this Plan. Covered Services are available to current Members and are subject to Cost Sharing, exclusions, limitations, authorization requirements, approvals and the terms and conditions of this Agreement. Molina will provide a Covered Service only if all of the following conditions are satisfied:

- The individual receiving Covered Services on the date the Covered Services are rendered is a Member
- The Covered Services are Medically Necessary and/or approved by Molina
- The services are identified as Covered Services in this Agreement
- The Member receives Covered Services from a Participating Provider, except for Covered Services that are expressly covered when rendered by Non-Participating Providers under the terms of this Agreement.

Members should read this Agreement completely and carefully in order to understand their coverage and to avoid being financially responsible for services that are not Covered Services under this Agreement.

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB) as defined by the Affordable Care Act (ACA) and its corresponding federal regulations. Services that are not EHBs will be specifically described in this Agreement. EHB coverage includes at least the ten (10) categories of benefits identified in the ACA and its implementing regulations. Members cannot be excluded from coverage in any of the ten (10) EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. on

the last day of the month that they turn age nineteen (19). This includes pediatric dental coverage and pediatric vision coverage. Pediatric dental services are not covered under this Agreement. These dental services can be purchased separately through a stand-alone dental product that is certified by the Marketplace.

Under the ACA and its corresponding federal regulations governing EHBs:

- Molina is not allowed to set lifetime limits or annual limits on the dollar value of EHBs provided under this Agreement.
- When EHB preventive services are provided by a Participating Provider, the Member will not have to pay any Cost Share amounts.
- Molina must ensure that the Cost Sharing that Members pay for all EHBs does not exceed an annual limit that is determined under the ACA.

For the purposes of this EHB annual limit, Cost Sharing refers to any costs that a Member is required to pay for EHBs. Cost Sharing includes Deductibles, Coinsurance and Copayments, but excludes Premiums and Member spending on non-Covered Services.

Mental Health Parity and Addiction Equity Act: Molina complies with the federal Mental Health Parity and Addiction Equity Act. Molina ensures that the financial requirements and treatment limitations on Mental Health Services or Substance Use Disorder benefits provided are no more restrictive than those on medical or surgical benefits.

Adoption Benefits: Molina will pay $4,000 payable to the Subscriber in connection with an adoption of a child when an adopted child is placed for adoption with the Subscriber within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the Subscriber, only one adoption indemnity benefit will be paid. The Subscriber shall refund Molina the full amount of the benefit paid if the post placement evaluation disapproves the adoption placement and/or a court rules the adoption may not be finalized because of an act or omission of the adoptive parent or parents that affects the child's health or safety. If each adoptive parent has coverage under separate health benefit Plans, Molina will pay its pro rata share. Adoption benefit is not subject to a Deductible.

Approved Clinical Trials: Molina covers routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition. A Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Members will never be enrolled in a clinical trial without their consent.

To qualify for coverage, an enrolled Member must be diagnosed with cancer or other life-threatening disease or condition, be accepted into an Approved Clinical Trial (as defined below) and have received Prior Authorization or approval from Molina. An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and:

1. 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 a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for Cancer Center Support Grants or
2. The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and Prior 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. If a Member qualifies, Molina cannot deny their participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Member's routine patient costs associated with their participation in an approved clinical trial for which they qualify. Members will not be denied or excluded from any Covered Services under this Agreement based on their health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial.

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 the Member incurs these costs while in an approved clinical trial. Costs excluded from coverage under this Plan include: The investigational item, device, or service itself, items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and any service inconsistent with the established standard of care for the patient's diagnosis.

All approvals and Prior 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. For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. Members will pay the Cost Sharing they would pay if the services were not related to a clinical trial. Members should contact Customer Support for further information.

Autism Spectrum Disorder: Molina covers the diagnosis and treatment of autism spectrum disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as defined by the Diagnostic and Statistical Manual, current edition.

Cancer Treatment: Molina provides the following coverages for cancer care. Preventive screening, and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more details). Molina covers prescribed oral chemotherapy and intravenously administered chemotherapy in parity.

Dental and Orthodontic Services: Molina does not provide pediatric dental services under this agreement. Dental and orthodontic services provided under this Agreement are limited to the following, which must be Prior Authorized:

- Dental services for radiation treatment
- Dental anesthesia
- Dental and Orthodontic services for Cleft Palate

Diabetes Services: Molina covers the following diabetes-related services:
Diabetes self-management training/education when provided by a Participating Provider

- Diabetic eye examinations (dilated retinal examinations) (limited to 1 visit per year)
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting
- Outpatient self-management training
- Routine foot care for Members with diabetes (including for care of corns, bunions, calluses, or debridement of nails).
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Preventive Services including:
    - Diabetes education and self-management
    - Diabetes (Type 2) screening
    - Screening for gestational diabetes
- Dietician services
- Nutritional counseling

For information regarding diabetes supplies, please refer to the "Prescription Drug" section.

Dialysis Services: Molina covers acute and chronic dialysis services, including in both home and outpatient settings, if all the following requirements are met:

- The services are provided by a Participating Provider.

- The Members satisfies all medical criteria developed by Molina

Emergency Services

Emergency Services are available twenty-four (24) hours a day, seven (7) days a week for Members. Members who think they are having an Emergency should call 911 right away and go to the closest Hospital or Emergency room. When seeking Emergency Services, Members should bring their Member ID card. Members who do not believe they need Emergency Services but who need medical help, should call their PCP, or call the 24-Hour Nurse Advice Line toll-free. Members should not go to an Emergency room if the condition is not an Emergency.

Emergency Services When Out of Service Area: Members should go to the nearest Emergency room for care when outside the Molina Service Area when they think they are having an Emergency. Please contact Customer Support within twenty-four (24) hours or as soon as possible.

Emergency Services Rendered by a Non-Participating Provider: Molina covers Emergency Services obtained from Non-Participating Providers in accordance with State and Federal Law. Emergency Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits at the in-network level. Members are not subject to Balance Billing for Emergency Services.

Post-Stabilization Services Rendered by a Non-Participating Provider: Except as set forth below when transfer to a Participating Provider Hospital is appropriate, or when any other benefit exclusions apply, Molina covers Post-Stabilization Services obtained from Non-Participating Providers in accordance with State and Federal law. Covered Post-Stabilization Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits at the in-network level. Members are not subject to Balance Billing for Post-Stabilization Services unless they consent to waive Balance Billing protections according to the required process under federal law.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services and Post-Stabilization Services. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina reserves the right to exclude benefits for the services once the Member has Stabilized sufficiently and it is appropriate to transfer the Member to a Participating Provider facility. Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility.

If the Member's Provider determines they are Stable for transfer and Molina arranges for transfer to a Participating Provider facility, and the Member refuses the transfer, additional services provided in the Non-Participating Provider facility, including Post-Stabilization Services, are not Covered Services. The Member will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of-Pocket.

Emergency Services Outside the United States: Molina does not cover Emergency Services outside of the United States.

Emergency Ground Ambulance Medical Transportation: Emergency ground ambulance medical transportation, or ground ambulance transport services provided through the 911 Emergency response system, are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. Covered Ground Ambulance Emergency Transportation Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing identified in the Schedule of Benefits. Non-Participating Providers of Emergency Ground Ambulance Medical Transportation may not Balance Bill for non-covered charges.

Emergency Air Ambulance Medical Transportation: Emergency air ambulance medical transportation services are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. Covered Air Ambulance Emergency Transportation Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing identified in the Schedule of Benefits. Non-Participating Providers of Emergency Air Ambulance Medical Transportation may not Balance Bill Members for non-covered charges.

Family Planning: Molina covers family planning services, including all methods of birth control approved by the FDA. Family planning services include:

- Diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated
- Prescription birth control supplies, including Emergency birth control supplies when filled by a Participating Provider pharmacist, or by a Non-Participating Provider in the event of an Emergency.
- Follow-up care for any problems Members may have using birth control methods issued by the family planning providers
- Laboratory tests if medically indicated as part of deciding what birth control methods a Member might want to use
- Pregnancy testing and counseling
- Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Any other outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain or remove a contraceptive.

Habilitation Services: Molina covers healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Habilitative services may include physical therapy, occupational therapy, speech-language pathology, and other services.

Home Healthcare: Molina covers home healthcare services on a part-time, intermittent basis to a Member confined to his or her home due to physical illness –

when Prior Authorized and provided by a contracted home healthcare agency. Molina covers the following home healthcare services:

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

Hospice Services: Molina covers hospice services for Members who are terminally ill (a life expectancy of 12 months or less). Members can choose hospice care instead of the traditional services covered by this Plan. Molina covers home hospice services and a semi-private room in a hospice facility limited to 45 days per calendar year. Molina also covers respite care up to fourteen days per lifetime.

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered Hospital services, except in the case of an Emergency Services received in a Non-Participating Provider hospital after admission to the Hospital for Emergency Services, will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a Hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider hospital are not Covered Services, and the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or Annual Out-of-Pocket Maximum.

Medically Necessary inpatient services are generally and customarily provided by acute care general Hospitals inside the Service Area. Non-Covered Services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services: Molina covers laboratory, radiology (including X-ray) and scanning services at a Participating Provider. Covered scanning services can include CT Scans, PET Scans and MRIs with Prior Authorization. Molina can assist Members select an appropriate facility for these services. Limited coverage for Medically Necessary dental and orthodontic X-rays is outlined in the Dental and Orthodontic Services section of this Agreement.

Mental Health Services: Molina covers a continuum of Mental Health Services when provided by Participating Providers and facilities acting within the scope of their license. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria. Molina may require authorization for coverage of services, including inpatient and certain outpatient services.

A mental disorder is a mental health condition identified in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental disorders covered under this Agreement may include severe mental illness of a person of any age. Severe mental illness includes 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 does not cover career, marriage, drug, parental or job counseling or therapy. In addition, treatment or testing within an inpatient setting related to Pervasive Developmental Disorders, including autism spectrum disorder, learning disabilities, and/or cognitive disabilities are not covered. Molina does not cover services for mental health conditions that the DSM identifies as something other than a Mental Disorder.

Molina generally covers the following Medically Necessary Mental Health Services:

- Inpatient care
- Crisis stabilization
- Short-term residential treatment services
- Partial hospitalization programs for mental health
- Intensive outpatient programs for adults and day treatment for children
- Psychological and neuropsychological testing
- Behavioral health procedures

Physician Services: Molina covers the following outpatient physician services including, but not limited to:

- Office visits, including:
  - Associated medical supplies
  - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs administered in a physician's office, an outpatient or an inpatient setting. These services are subject to either outpatient facility or inpatient facility Cost Sharing.
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy (Members may be subject to facility and professional Cost Sharing based on the place of service)
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care.

Phenylketonuria (PKU) and other Inborn Errors of Metabolism: Molina covers testing and treatment of phenylketonuria (PKU). Molina also covers 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 healthcare 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.

Pregnancy and Maternity: For prenatal care, Members may choose any Molina Participating Provider who is either an obstetrician/gynecologist (OB/GYN), certified nurse midwife, or nurse practitioner who is trained in women's health. Molina cover the following maternity care services:

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia
- Laboratory services
- Inpatient Hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that Members or Member's provider notifies Molina.

After talking with a Member, if the Member's Provider decides to discharge the Member and their newborn before the 48- or 96-hour period, Molina will cover post discharge services and laboratory services. Preventive, primary care, and Laboratory Services will apply to post discharge services, as applicable. Molina does not cover services for anyone in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Member who is a surrogate.

Pregnancy Termination: Pregnancy termination, to the extent permitted by State Law and Federal law is only covered:

- When the life of the mother is endangered by a physical disorder, physical illness or physical injury
- There is a life-endangering physical condition caused by, or arising from, the pregnancy itself
- When the pregnancy is the result of an alleged act of rape or incest

Note: Pregnancy termination services are office-based procedures and do not require Prior Authorization. Pregnancy termination services that are provided in an inpatient or outpatient Hospital setting require Prior Authorization.

Preventive Services: In accordance with the Affordable Care Act and as part of Member's Essential Health Benefits, Molina covers preventive services at no Cost Sharing for Members. Preventive services include:

- 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). Please visit the USPSTF website for preventive services recommendations at: www.uspreventiveservicestaskforce.org.
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- 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

- Preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

In accordance with State Law, preventive services include range of services for the diagnosis of infertility, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. As new recommendations and guidelines for preventive services are published and recommended by the government agencies identified above, they will become covered under this Agreement. Coverage will start for product years that begin one year after the date the recommendation or guideline is issued or on such other date as required by the ACA and its implementing regulations. The Plan 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 ACA, its corresponding federal regulations and applicable State Law.

Prosthetic, Orthotic, Internal Implanted and External Devices: Molina covers the internal and external devices listed below. Prior Authorization is required.
Internally implanted devices:

- Cochlear implants
- Hip joints
- Intraocular lenses
- Osseointegrated hearing devices
- Pacemakers

External devices:

- Artificial limbs needed due to loss resulting from disease, injury or congenital defect.
- Custom made prosthesis after mastectomy and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices to prevent or treat diabetes-related complications

Coverage is dependent on <u>all</u> the following requirements being 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 the Member's medical needs.
- The Member receives the device from the provider or vendor that Molina selects.

Prosthetic and orthotic device coverage includes services to determine whether the Member needs a prosthetic or orthotic device, fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse).

Molina does not cover orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. However, braces that stabilize an injured body part and braces to treat curvature of the spine are covered.

Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

The following reconstructive surgery services are not covered:

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

Rehabilitation Services: Molina covers services for the treatment of disease, injury, developmental delay, or other cause, by physical agents and methods to assist in the rehabilitation of normal physical bodily function, that is goal-oriented and where the person has potential for functional improvement and ability to progress. These services may include physical and occupational therapy, speech-language pathology, and aural therapy rehabilitation services (limited to 20 visits for the combined services per calendar year) in a variety of inpatient and/or outpatient settings.

Skilled Nursing Facility: Molina covers 30 days per calendar year at a skilled nursing facility (SNF) for a Member when the SNF is a Participating Provider and the services are Prior Authorized before they begin. Covered SNF services include:

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

Molina covers up to 60 days of Medically Necessary care at a long-term care facility following Hospitalization if You resided in that Long-Term Care Facility immediately prior to the Hospitalization, and all of the following are met:

- The Member's PCP determines that the Member's medical care needs can be met at the requested facility.
- The requested facility has all applicable licenses and certifications and is not under a stop placement order that prevents readmission.

- The requested facility agrees to accept payment for Covered Services at the rate Molina pays to similar facilities that are Participating Providers.
- The requested Facility agrees to abide by the standards, terms, and conditions Molina requires for similar facilities that are Participating Providers for (i) utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting

A “Long-Term Care Facility” or “Facility” for the purpose of this benefit is a nursing facility licensed under Chapter 18.51 of the Revised Code of Utah, a continuing care retirement community defined under Section 70.38.025 of the Revised Code of Utah, or an assisted living facility licensed under Chapter 18.20 of the Revised Code of Utah. The Member or their authorized representative, must obtain Prior Authorization for these services. Inpatient Hospital/Facility Services Coinsurance Cost Sharing will apply.

Substance Use Disorder (Inpatient and Outpatient): Molina covers Medically Necessary inpatient and outpatient treatment for substance use disorder. Inpatient coverage, in a Participating Provider Hospital, is only covered for medical management of withdrawal symptoms. Molina also provides coverage for substance use disorder treatment in a nonmedical transitional residential recovery setting when Prior Authorized. Molina covers the following outpatient care for treatment of substance use disorder:

- Day-treatment programs
- Individual and group substance abuse counseling
- Individual substance abuse evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs)
- Short-term residential programs

Molina does not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this Agreement. Nonmedical transitional residential recovery and substance use disorder services do not include therapy or counseling for any of the following: career, marriage, divorce, parental, behavioral, job, learning disabilities, and mental retardation.

Surgery (Inpatient and Outpatient): Molina covers the inpatient and outpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required. Inpatient surgical services include:

- Outpatient or ambulatory surgery center (including physician surgical charges, outpatient surgery)
- Hospital operating room
- Clinic
- Physician’s office

Outpatient surgery services provided in any of the following locations:

- Outpatient or ambulatory surgery center
- Hospital operating room

- Clinic
- Physician's office.

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

Transplant Services: Molina covers transplants of organs, tissue, or bone marrow at Participating Provider facilities when Prior Authorized. If a Participating Provider determines that a Member does not satisfy its respective criteria for a transplant, Molina will only cover services the Member received before that determination is made. Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor. In accordance with Molina guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor, or an individual identified as a potential donor, regardless of whether the donor is a Member. These services must be directly related to a covered transplant for the Member. Covered Services may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications. Molina guidelines for donor services are available by calling Customer Support.

Urgent Care Services: Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Members must get Urgent Care Services from a Participating Provider. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury. For after hours or Urgent Care Services, Members should call their PCP or the Nurse Advice Line. Members who are within the Service Area can ask their PCP what Participating Provider Urgent Care center to use. It is best to find out the name of a Participating Provider Urgent Care center ahead of time. Members who are outside of the Service Area may go to the nearest Emergency room.

Vision Services (Adult and Pediatric): Molina covers, for all Members, diabetic eye examinations (dilated retinal examinations) once ever calendar year. Molina also covers services for medical and surgical treatment of injuries and/or diseases affecting the eye.

Molina covers the following vision services for Members under the age of 19:

- Comprehensive vision exam limited to one every calendar year
- Glasses which are limited to one pair every calendar year
- Contact lenses which are limited to one pair of standard contact lenses every calendar year instead of glasses.
- Medically Necessary contact lenses for specified medical conditions.

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 Authorized. Laser corrective surgery is not covered.

Molina covers the following vision services for Members age 19 and older, when provided by a Participating Provider on Plans with routine adult vision benefits:

- Comprehensive vision exam limited to one every calendar year
- Routine retinal screening (Copayment applies)
- Glasses which are limited to one pair every calendar year
- Contact lenses in lieu of glasses

Members should refer to their Plan's Schedule of Benefits or Summary of Benefits and Coverage for this plan to learn more about routine adult vision coverage under this Plan, available at MyMolina.com or Molina Marketplace.com. Members should contact Molina Customer Support if they have any questions. Laser corrective surgery is not covered.

PRESCRIPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Molina covers drugs ordered by Providers, approved by Molina, and filled through a pharmacy that is a Molina contracted pharmacy. Covered drugs include over-the-counter (OTC) and prescription drugs. Molina also covers medical drugs ordered or given in a participating facility when provided in connection with a Covered Service. Prior Authorization may be required to have certain drugs covered. A Provider who is lawfully permitted to write prescriptions, also known as a Prescriber, may request Prior Authorization on behalf of a Member, and Molina will notify the Provider if the request is either approved or denied based upon Medical Necessity review.

Pharmacies: Molina covers drugs at retail pharmacies, specialty pharmacies, and mail order pharmacies within our Service Area. Members may be required to fill a drug with a contracted specialty pharmacy if the drug is subject to Food and Drug Administration (FDA) restrictions on distribution, requires special handling or provider coordination, or if specialized patient education is required to ensure safe and effective use. Drugs may be covered outside the Service Area for Emergency Services only, upon request. For a list of contracted pharmacies, please visit the Molina Marketplace website. A hardcopy is also available upon request made to Customer Support.

Molina Formulary: Molina establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the Formulary. The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with any coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on the Molina Marketplace website. A hardcopy is also available upon request. The list of products on the Formulary are chosen by a group of medical professionals from inside and outside of Molina. This group reviews the Formulary regularly and makes changes every three months based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs.

Access to Nonformulary Drugs: The Formulary lets Members and their Prescribers know which products are covered by the Plan's pharmacy benefit. The fact that a drug is listed on the Formulary does not guarantee that a Prescriber will prescribe it for a Member. Drugs that are not on the Formulary may not be covered by the Plan. These drugs may cost Members more than similar drugs that are on the Formulary if covered on "exception," as described in the next section. Members may ask for non-formulary drugs to be covered. Requests for coverage of non-formulary drugs will be considered for a medically accepted use when Formulary options cannot be used, and other coverage requirements are met. In general, drugs listed on the Formulary are drugs Providers prescribe for Members to get from a pharmacy and give to themselves. Most injectable drugs that require help from a Provider to use are covered under the medical benefit instead of the pharmacy benefit. Providers have instructions from Molina on how to get advanced approval for drugs they buy and treat Members with. Some injectable drugs can be approved to get from a pharmacy using the Plan pharmacy benefit.

Requesting an Exception: Molina has a process to allow Members to request clinically appropriate drugs that are not on the Formulary. Members may request coverage for

drugs that have step therapy requirements or other restrictions under the Plan benefit that have not been met. Prescribers may contact Molina's Pharmacy Department to request a Formulary exception. If the request is approved, Molina will contact the Prescriber.

If a prescription requires a Prior Authorization review for a Formulary exception, the request can be considered under standard or expedited circumstances.

- Any request that is not considered an expedited exception request is considered a Standard Exception request.
- A request is considered an expedited exception request if it is to treat a Member health condition that may seriously jeopardize their life, health, or ability to regain maximum function, or if they are undergoing current treatment using the drug and it is nonformulary. Trials of pharmaceutical samples from a Prescriber or a drug manufacturer will not be considered as current treatment.

Molina will notify the Prescriber of the coverage determination no later than:

- 24 hours following receipt of an expedited exception request
- 72 hours following receipt of a standard exception request

If the request is denied, Molina will send a letter to the Member and their Prescriber. The letter will explain why the drug or product was denied. It is within the Member's rights to purchase the drug at the full cost charged by the pharmacy. If the Member disagrees with the denial of the request, the Member can appeal Molina's decision. The Prescriber may request to talk to Molina reviewers about the denial reasons. The Prescriber may also request that an Independent Review Organization (IRO) review Molina's decision. The IRO will notify the requesting Provider of the IRO decision no later than:

- 24 hours following receipt of an appeal on a denied expedited exception request
- 72 hours following receipt of an appeal of a denied standard exception request.

Cost Sharing: Molina puts drugs on different levels called tiers based on how well they improve health and their value compared to similar treatments. The Plan pharmacy benefit has six Cost Sharing levels. For Tiers 1 through 4, the lower the Tier, the lower the Member's share of the cost will be. The Schedule of Benefits shows Member Cost Share for a one-month supply based on these tiers.
Here are more details about which drugs are on which tiers.

Drug Tier	Description
Tier 1	Preferred Generic drugs; Lowest Cost Share.
Tier 2	Preferred Brand-Name drugs; Higher Cost Sharing than Tier 1
Tier 3	Non-Preferred, Brand-Name and Generic drugs; Higher Cost Sharing than lower tier drugs used to treat the same conditions.

Tier 4	All Specialty Drugs; Brand-Name and Generic; Higher Cost Sharing than lower tier drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use the network specialty pharmacy.
Tier 5	Nationally recognized preventative service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 Cost Sharing.
DME	Durable Medical Equipment ("DME")- Cost Sharing applies; some non-drug products on the Formulary have Cost Sharing determined by the DME Coinsurance.

Cost Sharing on Formulary Exceptions: For drugs or other products that are approved on Formulary exception, the Member will have Tier 3 cost share for non-specialty products or a Tier 4 cost share for Specialty products. Please note, for nonformulary brand-name products that have a generic product listed on the formulary, if coverage is approved on exception, a Member's share of the cost will also include the difference in cost between the formulary generic drug and the brand-name drug

Drug Cost Sharing Assistance and Out-of-Pocket Costs: Cost Sharing reduction for any prescription drugs obtained by Members through the use of a discount card, a coupon provided by a prescription drug manufacturer, or any form of prescription drug third party Cost Sharing assistance will not apply toward any Deductible, or the Annual Out-of-Pocket Maximum under the Plan.

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Over-the-Counter Drugs, Products, and Supplements: Molina covers over-the-counter drugs, products, and supplements in accordance with State Law and Federal laws. Only over-the-counter drugs, products and supplements that appear on the Formulary may be covered.

Durable Medical Equipment (DME): Molina will cover DME rental or purchase costs, including for use with certain drugs, when obtained through a contracted vendor. Molina will also cover reasonable repairs, maintenance, delivery, and related supplies for DME. Members may be responsible for necessary DME repair or replacement costs if needed due to misuse or loss of the DME. Prior Authorization may be required for DME to be covered. Coverage may be under the medical benefit or the pharmacy benefit, depending on the type of DME. Please refer to the Formulary for DME and other non-drug products covered under the pharmacy benefit. Please refer to the MolinaMarketplace.com, or contact Customer Support for more coverage information.

Diabetic Supplies: Molina covers diabetic supplies on the Formulary such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, continuous glucose monitoring DME, blood glucose test strips, urine test strips, and select pen delivery systems for the administration of insulin.

Prescription Drugs to Stop Smoking: Molina covers a three-month supply of drugs to help Members stop smoking, with no Cost Share. Members should consult their

Provider to determine which drug is right for them. Covered drugs are listed on the Formulary.

Day Supply Limit: While Providers determine how much drug, product supply, or supplement to prescribe, Molina may only cover one month of supply at a time for certain products. The Formulary indicates “MAIL” for items that may be covered with a 3-month supply through a contracted mail order pharmacy or other Plan programs. Quantities that exceed the day supply limits on the Formulary are not covered, with few exceptions.

Proration and Synchronization: Molina provides medication proration for a partial supply of a prescription drug if the Member’s pharmacy notifies Molina that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs, synchronization is in the best interest of the Member, and Member agrees to the synchronization. The proration described will be based on the number of days’ supply of the drug dispensed.

Opioid Analgesics for Chronic Pain: Prior Authorization may be required for pharmacy coverage of opioid pain medications to treat chronic pain. Without a Prior Authorization, opioid claims have safety limits, including a shorter supply per fill and subject to restrictions on long-acting opioid drugs and combined total daily doses. These requirements do not apply to Members in the following circumstances: Opioid analgesics are prescribed to a Member who is a hospice patient, the Member was diagnosed with a terminal condition, or the Member is actively being treated for cancer. Molina will conduct a utilization review for all opioid Prior Authorization requests.

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs and their administration. Prior authorization requests for drugs to be used outside the FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity. These requests are reviewed against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on non-FDA label use. Drugs that Providers treat Members with will be subject to Cost Sharing specified for chemotherapy under the medical benefit for the place of service where treatment is given. Drugs that Members get from pharmacies will be subject to Cost Sharing specified for the pharmacy benefit. Please refer to the Schedule of Benefits for applicable Cost Sharing. Most new anti-cancer drugs require special handling and education and are considered Tier 4 specialty drugs under the pharmacy benefit.

Treatment of Human Immunodeficiency Virus (HIV): Molina covers prescription drugs for the treatment of HIV infection, or an illness or medical condition arising from or related to HIV. Drugs must be prescribed within the Provider’s scope of practice and approved by the United States Food and Drug Administration (FDA), including Phase III experimental or investigational drugs that are FDA approved and are administered according to protocol.

Mail Order Availability of Formulary Drugs: Molina offers Members a mail order option for certain drugs in tiers 1, 2, 3 and 5. Eligible drugs are marked “MAIL” on the Formulary. Formulary drugs can be mailed to a Member within 10 days from order request and approval. Through this option, Members can get a 3-month supply of

eligible drugs at reduced Cost Sharing. Cost Sharing for a 3-month supply through mail order is applied at a rate of two and a half times the one-month supply Cost Share at the drug's Formulary tier. Tier 4 Specialty drugs are not eligible for mail order programs. Refer to the Molina Marketplace website or contact Member Services for more information.

Off-Label Drugs: Molina will not deny coverage of off-label drug use solely on the basis that the drug will be used outside of the FDA-approved labeling. Molina does cover off-label drug use to treat a covered, chronic, disabling, or life-threatening illness. The drug must be approved by the FDA for at least one indication. The use must be recognized as standard and effective for treatment of the indication in any of the standard drug reference compendia or substantially accepted peer-reviewed medical literature. Molina may require that other treatments that are also standard have been tried or are not clinically appropriate if permitted under State Law. The off-label drug use request must demonstrate Medical Necessity to treat a covered condition when Prior Authorization is required.

Non-Covered Drugs: Molina does not cover certain drugs, including but not limited to:

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

Molina does not cover drugs to treat conditions that are benefit exclusions, including but not limited to:

- Cosmetic services
- Hair loss or growth treatment
- Infertility (other than treating an underlying diagnosis which caused infertility)
- Erectile dysfunction
- Sexual dysfunction

EXCLUSIONS

Certain items and services are excluded from coverage under this Agreement. This is not an exhaustive list of services that are excluded from coverage under this Plan.

Acupuncture Services: Acupuncture services are not covered.

Artificial Insemination and Conception by Artificial Means: All services related to artificial insemination and conception by artificial means are not covered.

Bariatric Surgery: Bariatric surgery for weight loss is not covered. Complications that occur as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure that result in an inpatient stay or an extended inpatient stay, as determined by Molina, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this product or any previous Molina Plan. This exclusion also applies if the surgery was performed while the Member was covered by a previous insurer or self-funded product prior to coverage under this Agreement

Certain Exams and Services: The following are not covered when performed solely for the purpose of:

- Obtaining or maintaining employment or participation in employee programs
- Obtaining medical coverage, life insurance coverage or licensing, or
- To comply with a court order or when required for parole or probation.

Chiropractic Services: Chiropractic services are not covered, except when provided in connection with occupational therapy and physical therapy.

Cosmetic Services: Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to any services specifically covered in any section of this Agreement.

Custodial Care: Assistance with activities of daily living are not covered. This exclusion does not apply to assistance with activities of daily living provided as part of covered hospice, skilled nursing facility, or inpatient Hospital care.

Dietician: A service of a dietitian is not a Covered Service except as specifically covered under Hospice Care, Preventive Care, and Diabetes Services benefits

Disposable Supplies: Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace- type bandages, diapers, underpads, and other incontinence supplies are not covered.

Erectile Dysfunction: Molina does not cover drugs or treatment for erectile dysfunction.

Experimental or Investigational Services: Molina does not cover Experimental or Investigational services; however, this exclusion does not apply to Services covered under Approved Clinical Trials section.

Felony, Riot, Insurrection or Illegal Activities: The following services are not covered for Members when incurred in connection with injury or illness arising from the voluntary commission of:

- A felony;
- An assault, riot or breach of peace;
- A Class A misdemeanor;
- Any criminal conduct involving the illegal use of firearm or other deadly weapon;
- Other illegal acts of violence when the insured is a voluntary participant.

Hair Loss or Growth Treatment: Items and services for the promotion, prevention, or other cosmetic treatment of hair loss or hair growth are not covered.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Intermediate Care: Care in a licensed intermediate care facility is not covered. This exclusion does not apply to services covered under in the Covered Services section.

Non-Healthcare Items and Services: Molina does not cover services that are not healthcare services, for example:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills, teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching Members how to read, if they 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
- Examinations related to job, athletic (sports physicals), or recreational performance

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

Massage Therapy: Massage therapy is not covered.

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

Oral Nutrition: Outpatient oral nutrition is not covered, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

Private Duty Nursing: Nursing services provided in a facility or private home, usually to one patient, are not covered. Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a home healthcare agency.

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

- A Hospital,
- A skilled nursing facility,
- Inpatient respite care covered in the Hospice Care section,
- A licensed facility providing crisis residential services covered under Mental Health Services (inpatient and Outpatient) section, or
- A licensed facility providing transitional residential recovery services covered under the Substance Use Disorder (Inpatient and Outpatient) section.

Routine Foot Care Items and Services: Routine foot care items and services are not are not covered, except for Members with diabetes.

Services Not Approved by the FDA: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA are not covered. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to services covered under Approved Clinical Trials section. Please refer to the Complaints, Grievances and Appeals section for information about denied requests for Experimental or Investigational services.

Services Provided Outside the Service Area: Any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. Only Emergency Services and Post-Stabilization Services outside the Service Area are covered to treat an Emergency Medical Condition. Emergency Services outside the United States are not covered. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Customer Support for more information.

Services Provided Outside the United States: Molina does not cover services performed outside of the United States, including Emergency Services.

Services Performed by Unlicensed People: Services performed by people who are not required by State Law to possess valid licenses or certificates to provide healthcare services are not covered, except otherwise covered by this Agreement.

Services Related to a Non-Covered Service When a service is not covered, all services related to the non-Covered Service are not covered. This exclusion does not apply to services Molina would otherwise cover to treat complications of the non-Covered Service. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service. If a Member later suffers a life-threatening complication such as a serious infection, this exclusion would not apply. Molina would cover any services that Molina would otherwise cover to treat that complication.

Sexual Dysfunction: Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications.

Surrogacy: Services for anyone in connection with a surrogacy arrangement are not covered, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel and Lodging Expenses: Travel and lodging expenses are not covered. Molina may pay certain expenses that Molina preauthorizes in accordance with Molina's travel and lodging guidelines. Molina's travel and lodging guidelines are available from Customer Support.

CLAIMS

Filing a Claim: Providers must promptly submit to Molina claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Molina and must include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Provider to Molina within 365 calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and Provider has been furnished with the correct name and address for Molina. If Molina is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to Molina within 30-45 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to Molina within these timelines are not be eligible for payment and Provider waives any right to payment.

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract, State Law and Federal Law. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, generally Molina will pay the Provider of service within 45 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements.

Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was approved or does not require approval, Molina will repay the Member. The Member must submit the claim for reimbursement within 12 months from the date they made the payment. Members must mail this information to Molina Customer Support at the address on the inside cover of this Agreement. The Member will need to mail Molina a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number.

If the bill is for a prescription, the Member will need to complete a Reimbursement Form found in the Pharmacy section of the Molina website. Include a copy of the prescription label and pharmacy receipt when submitting this form to the address as instructed in the form. After Molina receives the request for reimbursement, Molina will respond to the Member within 30 calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member. If the claim is denied, Molina will send the Member a letter explaining why the claim was denied. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

Paying Bills: Members should refer to their Schedule of Benefits for their Cost Sharing responsibilities for Covered Services. Members may be liable to pay full price for services when:

- The Member asks for and gets medical services that are not Covered Services.
- Except in the case of Emergency Services, the Member asks for and gets healthcare services from a Provider or facility that is a Non-Participating Provider without getting a prior approval from Molina.

If Molina fails to pay a Participating Provider for providing Covered Services, the Member will not be responsible for paying the Participating Provider for any amounts owed by Molina. This does not apply to Non-Participating Providers.

LEGAL NOTICES

Third Party Liability: Molina is entitled to reimbursement for any Covered Services provided for a Member under this plan to treat an injury or illness caused by the wrongful act, omission, or negligence of a third party, if a Member has been made whole for the injury or illness from the third party or their representatives. Molina shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and the Member shall cooperate to fully and completely assist in the protection the rights of Molina, including providing prompt notification of a case involving possible recovery from a third party. Members must reimburse Molina for the reasonable cost of services paid by Molina to the extent permitted by State Law immediately upon collection of damages by the Member, whether by action or law, settlement or otherwise; and fully cooperate with Molina's effectuation of its lien rights for the reasonable value of services provided by Molina to the extent permitted under State Law. Molina's lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

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

Changes in This Agreement: Any modification of this Agreement during the term of the policy may not affect the obligations of a party to the Agreement unless the modification is in writing and agreed to by the party against whose interest the modification operates.

Acts Beyond Molina's Control: If circumstances beyond the reasonable control of Molina, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Molina and the Participating Provider shall provide or attempt to provide Covered Services in so far as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina nor any Participating Provider shall have any liability or

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

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

Non-Discrimination: Molina does not discriminate in hiring staff or providing medical care based on pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity, or genetic information. Molina does not unfairly discriminate against any licensed class of health care providers by structuring contract exclusions that exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice.

Genetic Information: Molina will not collect genetic information from the Member for purpose of underwriting or otherwise. Molina will not request or require the Member to take any genetic tests. Molina will not adjust premiums or otherwise limit coverage based on genetic information.

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: A Member 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. Consent may be refused in Molina's discretion.

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

Invalidity: If any provision of this Agreement is held illegal, invalid or unenforceable in a judicial proceeding, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall remain operative and in full force and effect.

Notices: Any notices required by Molina under this Agreement will be sent to the most recent address or record for the Subscriber. The Subscriber is responsible for reporting any change in address to the Marketplace.

Legal Action: No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses: After 2 years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability (as defined in the Agreement) commencing after the expiration of such 2-year period. No claim for loss incurred or disability (as defined in the Agreement) commencing after 2 years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Agreement.

Proofs of Loss: If required or appropriate as determined by Molina, notice and written proof of loss relating to a claim must be furnished to Molina at the address on the first page of this Agreement within 365 days after the occurrence or start of the loss on which the claim is based to validate and preserve the claim. Notice of loss given by or on behalf of the Member to any authorized agent of Molina within this state, with particulars sufficient to identify the Agreement, is notice to the insurer. Failure to give any notice or file any proof of loss required by the Agreement within the time specified in the Agreement does not invalidate a claim made by the Member, if the Member shows that it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible..

Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement

Wellness and Other Program Benefits: This Agreement includes access to a wellness program offered to encourage Members to complete health activities that support their overall health. The program is voluntary and available to all subscribers at no cost. The program is additionally available to Dependents 18 years and older at no cost. Molina may offer you rewards or other benefits for participating in certain health activities and programs. The rewards and program benefits available to Members may include premium credits or other benefits such as gift cards.

Members should consult with their PCP before participation. The wellness program is optional, and the benefits are made available at no additional cost to eligible members. For more information, please contact Customer Support.

COMPLAINTS, GRIEVANCES, AND APPEALS

Members that have a problem with any Molina services can contact Molina Complaints and Appeals or send Molina the problem or complaint in writing by mail or filing online.

Definitions: Capitalized terms in the Complaints, Grievances and Appeals section only apply to this section and have the following definitions:

Authorized Representative: An individual authorized in writing by a Member or State Law to act on their behalf in requesting a healthcare service, obtaining claim payment, or during the internal appeal process. A health care provider may act on behalf of a Member without their express consent when it involves an Urgent Care Service.

Final Adverse Benefit Determination: An Adverse Benefit Determination that is upheld after the internal appeal process. If the period allowed for the internal appeal elapses without a determination by Molina, then the internal appeal is a Final Adverse Benefit Determination.
Independent Review Organization (IRO): An organization renders an independent and impartial decision on a Final Adverse Benefit Determination.

Post-Service Claim: Molina rendered an Adverse Benefit Determination for a service that completed.

Pre-Service Claim: Molina rendered an Adverse Benefit Determination, and the requested service was not completed.

UID: The Utah Insurance Department and Office of the Commissioner.

Urgent Care Services Claim: Molina rendered an Adverse Benefit Determination, and the requested service did not complete, where the application of non-Urgent Care appeal periods could seriously jeopardize: a Member's life or health or that of their unborn child; or in the opinion of the treating Provider, would subject a Member to severe pain unless a Member receives the care or treatment that is the subject of the Internal Appeal.
Members that have a problem with any Molina services can contact Molina Customer Support or send Molina the problem or complaint in writing by mail or filing online.

Complaint and Appeals Contact Information:

Molina Complaints and Appeals
7050 Union Park Center, Suite 200
Midvale, UT, 84047
Website: MolinaMarketplace.com
Toll-Free Phone: 1 (888) 858-3973. TTY users may dial 711
or

Utah Insurance Department Consumer Services
4315 S 2700 W Ste 2300 Taylorsville, UT 84129
801-957-9280
E-mail: healthappeals.uid@utah.gov

Complaint: A Complaint is any dissatisfaction that a Member has with Molina or any Participating Provider that is not related to the denial of healthcare services. For example, a Member may be dissatisfied with the hours of availability of a Member's doctor. Issues relating to the denial of healthcare services are Appeals and should be filed by mail, phone or online with Molina or the Utah Insurance Department (UID). Molina will respond to a Member complaint no later than 60 days from receipt of the Complaint.

Internal Appeal: A Member, Member's Authorized Representative, or a treating Provider or facility may submit an appeal of an Adverse Benefit Determination. Molina will provide the Member with the forms necessary to initiate an appeal. A Member may request these forms by contacting Molina Complaints and Appeals. While Member's are not required to use Molina's forms, Molina strongly encourages that an appeal be submitted on such form to facilitate logging, identification, processing, and tracking of the appeal through the review process. If a Member need assistance in preparing the appeal, or in submitting an appeal verbally, a Member may contact Molina for such assistance. A Member or their Authorized Representatives must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination. Within 5 business days of receiving an appeal, Molina will send a Member or their Authorized Representative a letter acknowledging receipt of the appeal. Member's coverage will remain in effect pending the outcome of their internal appeal. The appeal will be reviewed by personnel who were not involved in the making of the Adverse Benefit Determination and will include input from healthcare professionals in the same or similar specialty as typically manages the type of medical service under review.

Timeframe: Molina will respond to the following types of appeal requests in the following time frames:

- Urgent Care Services: Within 72 hours
- Pre-Service Claim: Within 30 days
- Concurrent service (a request to extend or a decision to reduce a previously approved course of treatment): Within 72 hours for in-network
- Post-Service Claim: Within 60 days

Exhaustion of Process: The preceding procedures and processes are mandatory and must be exhausted prior to establishing litigation or any administrative proceeding regarding matters within the scope of this "" section.

General Rules and Information: A Member must cooperate fully with Molina to promptly review and resolve a complaint or appeal. In the event a Member does not fully cooperate with Molina, it will be deemed that the Member has waived their right to have the Complaint or Appeal processed within the periods set forth above. Molina will offer to meet with a Member by telephone or in person. Molina will make appropriate arrangements to allow telephone conferencing or an in-person meeting upon request at

Molina administrative offices. Molina will make these arrangements with no additional charge to a Member. During the review process, Molina will review the services in question without regard to the decision reached in the initial determination. Molina will provide the Member with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when Molina made the initial Adverse Benefit Determination. A "full and fair" review process requires Molina to send any new medical information to review directly so a Member have an opportunity to review the claim file.

Independent Review Process: A Member may request an independent review of an Adverse Benefit Determination only after exhausting the Molina's internal review process described above unless: (1) Molina agrees to waive the internal review process; (2) Molina has not complied with the requirements of the internal review process, except where those failures are de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the Member and are not part of a pattern or practice failing to follow the requirements; or (3) a Member has requested an expedited independent review at the same time.

Molina will pay the cost for an IRO to conduct a review of an Adverse Benefit Determination. A Member may request an independent review at regardless of the dollar amount of the claim or services involved. A Member must file a request with UID for an independent review no later than 180 days after a Member receives the Final Adverse Benefit Determination notice from Molina. If a Member sends the request to Molina, Molina will forward the request to the UID within 1 business day of receipt. A Member must use the Independent Review Request Form available at www.insurance.utah.gov or from Molina Complaints and Appeals Unit to file the request. The independent review request must contain an authorization for the necessary parties to obtain medical records for purposes of deciding on the independent review request. The independent review decision is binding on Molina and the Member except to the extent that other remedies are available under federal law and State Laws.

Upon receipt of the Independent Review Request Form, UID will send a copy of the request to Molina. Within 5 business days following receipt of the request, Molina will determine whether (a) the individual was a Member at the time of rescission or the healthcare service was requested or provided; (b) a healthcare service that is the subject of an Adverse Benefit Determination is a Covered Service; (c) the Member has exhausted Molina's internal review process described above; and (d) the Member has provided all the information and forms required for the independent review. Within 1 business day of making these determinations, Molina will notify UID and the Member in writing whether the request is complete and eligible for independent review. If the request is not complete, Molina will inform the Member and UID in writing what information or materials are needed to make the request complete. If the request is not eligible for independent review, Molina will inform the Member and UID in writing of the reasons why the request is not eligible for independent review and inform the Member that the determination may be appealed to UID. UID may decide in accordance with the terms of this Agreement that the request is eligible for independent review despite Molina's determination that the request is not eligible in which case the request will be independently reviewed. If a request is eligible for independent review, UID will:

- Assign on a random basis an IRO from the list of approved IROs based on the nature of the healthcare service that is subject to review;
- Notify Molina of the assignment and require Molina to provide to the IRO the documents and any information considered in making the Adverse Benefit Determination within 5 business days; and
- Notify the Member that the request has been accepted and the Member may submit additional information to the IRO within 5 business days of receipt of the UID's notice.

The IRO will forward to Molina within 1 business day of receipt any information submitted by the Member. The IRO will provide notice of its decision to uphold or reverse the Adverse Benefit Determination within 45 calendar days to the Member, Molina and UID. If the Adverse Benefit Determination is reversed, Molina will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within 1 business day of the notice.

Expedited Independent Review Requests: An expedited independent review is available when the Adverse Benefit Determination:

- Involves a medical condition which would seriously jeopardize the life and health of the Member or jeopardize the Member's ability to regain maximum function;
- In the opinion of the Member's attending provider, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Adverse Benefit Determination; or
- Concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services, but has not been discharged from a facility.

Upon receipt of the Independent Review Request Form, UID will immediately send a copy of the request to Molina. Immediately upon receipt, Molina will determine whether:

(a) the individual was a Member at the time the healthcare service was requested or provided;
(b) a health care service that is the subject of an Adverse Benefit Determination is a Covered Service; and
(c) the Member has provided all the information and forms required for the expedited independent review. Molina will immediately notify the UID and the Member whether the request is complete and eligible for expedited independent review.

If the request is not complete, Molina will inform the Member and the UID in writing what information or materials are needed to make the request complete. If the request is not eligible for expedited independent review, Molina Healthcare will inform the Member and UID in writing of the reasons why the request is not eligible for expedited independent review and inform the Member that the determination may be appealed to UID. UID may decide in accordance with the terms of this Agreement that the request is eligible for expedited independent review despite Molina's determination that the request is not eligible in which case the request will be independently reviewed If a request is eligible for expedited independent review, the UID will:

- Assign on a random basis an IRO from the list of approved IRO based on the nature of the health care service that is subject to review;

- Notify Molina of the assignment and require Molina within five days to provide to the IRO the documents and any information considered in making the Adverse Benefit Determination; and
- Notify the Member that the request has been accepted and the Member may submit additional information to the IRO within five days of receipt of the UID's notice.

The IRO will forward to Molina within 1 business day of receipt any information submitted by the Member. The IRO will as soon as possible, but not later than 72 hours after receipt of the request for an expedited independent review, provide notice of its decision to uphold or reverse the Adverse Benefit Determination to the Member, Molina and UID. If the notice is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of notification of the decisions. If the Adverse Benefit Determination is reversed, Molina will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within 1 business day of the notice.

Independent Review Requests Based on Experimental or Investigational Services: If a Member submits a request for independent review involving Experimental or Investigational Services, the request must contain a certification from the Member's Provider that (a) standard health care service or treatment has not been effective in improving the Member's condition; (b) standard healthcare services or treatments are not medically appropriate for the Member; or (c) there is no available standard healthcare service or treatment covered by the Plan that is more beneficial than the recommended or requested health care service or treatment. Upon receipt of the Independent Review Request Form involving experimental or investigation services or treatments, the UID will send a copy of the request to Molina. Within 5 business days, or 1 business day for expedited requests, following receipt of the request, Molina will determine whether (a) the individual was a Member at the time the health care service was requested or provided; (b) the health care service that is the subject of an Adverse Benefit Determination is a Covered Service, except that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit in the EOC; (c) the Member has exhausted Molina's internal review process described above, unless the request is for an expedited review; and (d) the Member has provided all the information and forms required for the independent review. Within one business day of making these determinations, Molina Healthcare will notify the UID and the Member in writing whether the request is complete and eligible for independent review. If the request is not complete, Molina Healthcare will inform the Member and the UID in writing what information or materials are needed to make the request complete.

If the request is not eligible for independent review, Molina Healthcare will inform the Member and the UID in writing of the reasons why the request is not eligible for independent review and inform the Member that the determination may be appealed to the Utah Insurance Commissioner. The UID may decide in accordance with the terms of this EOC that the request is eligible for independent review despite Molina Healthcare's determination that the request is not eligible in which case the UID will the request will be independently reviewed. If a request is eligible for independent review, the UID will:

• Assign on a random basis an IRO from the list of approved IRO based on the nature of the health care service that is subject to review;
• Notify Molina Healthcare of the assignment and require Molina within five business days, or one business day for a request for expedited review, to provide to the IRO the documents and any information considered in making the Adverse Benefit Determination; and
• Notify the Member that the request has been accepted and the Member may submit additional information to the IRO within 5 business days, or one business day for expedited review requests, of receipt of the Utah Insurance Commissioner's notice. The IRO will forward to Molina within 1 business day of receipt any information submitted by the Member. Within one business day of receipt of the request, the IRO will select a one or more clinical reviews to conduct the review. The clinical reviewer will provide the IRO a written opinion with 20 calendar days, or 5 calendar days for an expedited review, after being selected. The IRO will decide based on the clinical reviewer's opinion within 20 calendar days of receipt of the opinion, or 48 hours in the case of an expedited review, and provide notice of its decision the Member, Molina and the Utah Insurance Commissioner. If the Adverse Benefit Determination is reversed, Molina will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within one business

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing"(sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Molina Healthcare network of participating providers (or in-network).

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments or coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may file a complaint with the federal government by visiting https://www.cms.gov/nosurprises or call 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجانًا لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

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

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

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

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

توجه! اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان در اختیار شما است. با خدمات اعضاء تماس بگیرید. شماره تلفن مربوطه در پشت کارت عضویت شما درج شده است. (Farsi)

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

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

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

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

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប៊ែលឬពុម្ពអក្សរធំដោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកដោយមិនគិតថ្លៃបន្ថែម។ (Cambodian)