

Molina Healthcare of Wisconsin, Inc. Marketplace

2024

Agreement and Individual Evidence of Coverage

Please read this Agreement carefully. If You are not satisfied with Your Agreement, You can return it to Us within 10 days of Your receipt of the Agreement. If You return it to Us within the 10-day period, We will treat this Agreement as if it had never been issued. We will return all of Your Premium payments to You. If You return this Agreement under this provision, You will be responsible for payment of any health care service You or a Dependent received before You returned the Agreement.

Molina Healthcare of Wisconsin, Inc.
11002 W. Park Place
Milwaukee, WI 53224-9931

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First Page Notices Placeholder

Pediatric Dental Notice: NOTICE: THIS AGREEMENT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS COVERAGE IS AVAILABLE IN THE HEALTH INSURANCE MARKETPLACE. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR THE FEDERALLY FACILITATED HEALTH INSURANCE MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STANDALONE DENTAL PRODUCT.

Services for Limited Plans for American Indians and Alaska Natives

- For individual Plans with zero Cost Sharing, American Indians/Alaskan Natives do not have Cost Sharing when they receive services Covered Services from Participating Providers.
- For individual Plans with limited Cost Sharing, American Indians/Alaskan Natives do not have Cost Sharing when they receive Covered Services Indian Health Care Provider, or from another Provider if they have a referral from an Indian Health Care Provider. For more information, please visit the MolinaMarketplace.com .

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

MOLINA REFERENCE GUIDE

Service	Need	Where to Go
Emergency Services	<ul style="list-style-type: none"> Treatment of an Emergency Medical Condition 	<p>Call 911, or go to any hospital emergency room, even if it is a Non-Participating Provider or outside of the Service Area.</p>
Getting Care	<ul style="list-style-type: none"> Urgent Care <ul style="list-style-type: none"> Minor Illnesses Minor Injuries Virtual Care Physicals and check-ups Preventive care Immunizations (shots) 	<p>Call your Doctor</p> <p>Urgent Care Centers Find a provider or urgent care center MolinaHealthcare.com/ProviderSearch</p> <p>Virtual Care www.teladoc.com/molinamarketplace 1-800-TELADOC</p> <p>24-Hour Nurse Advice Line 1 (888) 275-8750 (English) 1 (866) 648-3537 (Spanish)</p>
Online Access	<ul style="list-style-type: none"> Find or change your doctor View benefits and Member Handbook View or print ID card Track claims 	<p>Go to MyMolina.com</p> <p>Download the Molina Mobile App</p> <p>Visit the Provider Directory MolinaMarketplace.com</p>
Plan Details	<ul style="list-style-type: none"> Answers about your plan, programs, services, or prescription drugs ID card support Access to care Prenatal care Well-infant visits Payment questions Provider Complaints 	<p>Molina Customer Support Center Molina Healthcare of Wisconsin 11002 W. Park Place Milwaukee, WI 53224 1 (888) 560-2043 TTY/TDD: 711 Monday through Friday, 8:00 a.m. to 6:00 p.m. Central time</p> <p>Go to MyMolina.com</p>
Eligibility & Enrollment	<ul style="list-style-type: none"> Eligibility questions Add a Dependent Report change of address or income 	<p>Contact Healthcare.gov 1(800) 318-2596</p> <p>Go to Healthcare.gov</p>

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Policy Issuance: This Molina Healthcare of Wisconsin, Inc. Agreement and Individual Evidence of Coverage (also called the “Agreement”) is issued by Molina Healthcare of Wisconsin, 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 and 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.

Interpreter Services: Molina offers interpreter services for any Member who may need language assistance to understand and obtain health coverage under this Agreement. Molina provides these services in a timely manner 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.

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 of Molina. No agent of Molina has authority to change this Agreement and incorporated documents or to waive any of its provisions.

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 Central 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 40 years, Molina is excited to be your Plan.

We're providing you this 2024 Molina of Wisconsin Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

- How you can get services through Molina, including:
 - How to get an interpreter
 - How to choose a Primary Care Provider (PCP)
 - Making an appointment
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Molina Member
- How to check in 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)-560-2043.

We look forward to serving you,

Molina Marketplace

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 a special meaning used in any section of this Agreement 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 and applicability of State or Federal Surprise Billing protections.

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 Subscriber or a particular Dependent, 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 Subscriber or a particular Dependent 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 all eligible dependents 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 for non-network providers, or the cost of non-covered services.

Covered Service or Covered Services: Medically Necessary services, including some medical devices, 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.

Distant Site: The site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

Drug Formulary or Formulary: A list of prescription drugs this Molina Plan covers. The Drug Formulary 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. 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 adequate 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 Transportation Services: Appropriate ambulance transfers undertaken prior to an Emergency Medical Condition being stabilized.

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.

Essential Health Benefits or EHB: A set of 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 underlying medical condition for which such procedure, medication, facility or device was prescribed.

FDA: The United States Food and Drug Administration.

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 Premiums. 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.

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

Molina Healthcare of Wisconsin, Inc. Agreement and Individual Policy: 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: A Participating Provider who provides 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 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 you 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.

Schedule of Benefits: A comprehensive listing of Covered Services with 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 stabilize means 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 Wisconsin. It consists of the state's constitution, statutes, regulations, sub-regulatory guidance state regulatory agency directives and common law.

Telehealth: 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.

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 when eligible individuals can submit an application 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 experienced certain life changes established by the Marketplace. The Effective Date of your 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. Dependents must meet the eligibility requirements, as established by the Marketplace. Dependents are subject to the terms and conditions of this Agreement. The following individuals are 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 your grandchild. Each child is eligible to apply for enrollment as a Dependent until the age of 26.
- **Child with a Disability:** A child who reaches the age of 26 is eligible to continue to be a Dependent if the child meets the following eligibility criteria:
 - The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
 - The child of any age is chiefly dependent upon the Subscriber for support and maintenance if they are permanently and totally disabled.
 - A child may remain covered by Molina as a Dependent for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.
- **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 and State Law.

Adding New Dependents: An individual may become eligible to be a Dependent after the Member as the Subscriber becomes a Member of this Plan. The eligible individual may be able to enroll as a Dependent in Your Plan. You must contact the Marketplace

and submit any required application(s), forms and requested information for the Dependent. Your requests 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 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
- The date of Your marriage
- 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, placement for adoption, placement in foster care, adoption, placement for adoption, child support, or other court order.
- The Child gains status as a citizen, national, or lawfully present individual

Newborn Child: A newborn child of a Subscriber is eligible as a Dependent at birth. A newborn is initially covered for up to 60 days, including the date of birth. A newborn child is eligible to continue enrollment if they enrolled within Molina within 60 days. If a Member fails to make any required payment beyond the 60-day period, coverage will not continue, unless the Member makes all past due payments and in addition pays interest on such payments at the rate of five and one-half (5.5) percent. Please note, claims for newborns 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 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. Central time on the last day of the calendar year that the Dependent child attains age 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 is entered between the Dependent Spouse and Subscriber.
- The date a termination of the domestic partnership decree between the Subscriber and Domestic Partner is entered.
- For Child-Only Coverage, at 11:59 p.m. Central time on the last day of the calendar year in which the non-Dependent Member reaches the limiting age of

21. Member and any Dependents may be eligible to enroll in other products offered by Molina through the Marketplace.

Continued Eligibility: If a Member is no longer eligible for coverage under this Plan, Molina will send a written notification at least 60 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 the current month (this is the “Due Date”). Molina will send a Subscriber a 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 credit in advance to lower their Premium.

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

Third Party Payment of Premium and Cost-Sharing: Premium payments from third-parties, except those required by law or made by a person or entity indicated below, may not be accepted:

1. A Ryan White HIV/AIDS program under title XXVI of the Public Health Service Act;
2. An Indian tribe, tribal organization, or urban Indian organization;
3. A local, state, or Federal government program, including a grantee directed by a government program to make payments on its behalf;
4. Family of a Member; and
5. Religious institutions and other non-profits when criteria is met pursuant to Molina’s policy.

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 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.

- **Grace Period for Subscribers with APTCs:** Molina will provide a Grace Period of 3 consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, is receiving 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. Central 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 10 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 pay all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. Central time on the last day 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 they and their Dependent's coverage ended due to non-payment of Premiums. Members may appeal a termination decision by Molina. Please refer to the MolinaMarketplace.com, the Appeals and Grievances section of this Agreement or contact Customer Support for more information of how to file an appeal or this decision.

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 for the following plan year, Molina may require that a Subscriber pay any past due Premiums, limited to no more than the past 12 months. 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.

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.

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. Central time 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 of a material fact, if a Member's coverage is terminated, any Premium payments received on behalf 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 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 of a material fact, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation. 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, not including Dependents, no longer resides within the Service Area. Coverage will end at 11:59 p.m. Central time 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. Central time 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 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 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 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;
- Treatment received during the second or third trimester of pregnancy through the postpartum period, or a course of treatment received at any stage of pregnancy that is related to a pregnancy;
- Any treatment being received for a terminal illness; 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 your 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 Emergency facility, even if it is a Non-Participating Provider or outside of the Service Area.

24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is 1-888-275-8750 (English) or 1-866-648-3537 (Spanish).

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 Member's Deductible or OOPM. However, a Member may receive Covered Services from a Non-Participating Provider for the following:

- Emergency Services
- Post-Stabilization Services, unless the Member waives Balance Billing protections
- Services by a Non-Participating Provider at a Participating Facility, unless the Member waives Balance Billing protections
- Air ambulance services
- Services from a Non-Participating Provider that are subject to Prior Authorization

- Exceptions described below under “Non-Participating Provider at a Participating Provider Facility”
- 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. Because Non-Participating Providers are not in Molina's contracted Provider network, unless Balance Billing protections apply, they may Balance Bill Members for the difference between Molina's Allowed Amount and the rate that they charge.

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 Policy: 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; However, Members will be 100% responsible for payment for such services and the payments for such services will not apply to their Deductible or OOPM for any of the services under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement and refer to applicable Balance Billing protections through Federal and State Law.

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. Change 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 you may not be able to select the PCP that you want. This may happen because:

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

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 email only

Covered Services provided through store and forward technology must include an in-person office visit to determine diagnosis or treatment. Please refer to the “Definition” section for explanation.

Non-Participating Provider to Provide a Covered Service: If there is no Participating Provider that can 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 a Participating Providers. Prior Authorization is required before the initiation of the service by a Non-Participating Provider in this scenario.

Moral Objections:

Some Participating Providers may object to provide some of the Covered Services 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), or pregnancy termination services. Members should contact their Participating Providers or Customer Support to make sure they can get the healthcare services that they need. 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 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 product 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 its doctors have failed to respond to their disability access needs, they may file a grievance with Molina. Please refer to the Appeals and Grievances section of this Agreement for information regarding how to file a grievance.

PRIOR AUTHORIZATION

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 on their behalf.

Please view MolinaMarketplace.com/WIGetCare 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 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 timeframes apply if use of the standard ones:

- 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.

F: Do not need PA. However, Post-Stabilization Services received in the inpatient department of a hospital are subject to the Inpatient Concurrent Review process discussed below.

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

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, visit MolinaMarketplace.com or contact Customer Support. Molina can explain how this type of decision is made.

Medical Necessity determination criteria for coverage of healthcare services includes whether services are appropriate to the Member’s diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Medical Necessity is based on generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.

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 written notification informing them why the 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 also in the section of this Agreement titled “Complaints”. Members may obtain the clinical review criteria used to determine Medical Necessity for authorization requests by contacting Customer Support.

If a Member or their Provider decides to proceed with a service that has not been authorized by Molina, the Member will have to pay the cost of those services.

Utilization Review: Licensed Molina staff process Prior Authorization requests and conducts. Upon request, Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations. Members will be directed back to their Provider to discuss options when a member is not authorized for a service.

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 Prior Authorization at least 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 48 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 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; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- 2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; 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 under any other Plan.
- B.
 - 1. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
 - 2. Coverage that is obtained by virtue of Membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - 2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
- 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 a 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.

COST SHARING

Molina requires Members to pay Cost Sharing for certain Covered Services under this Agreement. Members should review their Summary of Benefits and Coverage 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. Cost sharing for covered prescription drugs is due at the time the network pharmacy dispenses the Member's prescription. Formulary tiering and plan design cost sharing are described in the "Prescription Drugs" section of this Agreement and Schedule of Benefits for your plan.

COVERED SERVICES

This section describes the Covered Services available with this Plan. Covered Services are available to current Members and may be subject to Cost Sharing, exclusions, limitations, authorization requirements, approvals and the terms and conditions of this Agreement. Molina will provide and pay for 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 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 10 categories of benefits identified in the ACA and Federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. Central time on the last day of the month that they turn age 19. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage.

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.
- Molina must ensure that the Cost Sharing that Members pay for all EHBs, that are not preventive services, 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.

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 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 (ASD): 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.

Molina may require a Member to obtain a second opinion from another health care provider at Molina's expense. This provider must be experienced in the use of empirically validated tools specific for Autism Spectrum Disorders. The Member, the Member's parent or the Member's authorized representative and Molina must agree upon the provider. Coverage for the cost of a second opinion will be in addition to the benefit mandated by Section 632.895 (12m), Wisconsin Statutes, as amended.

Benefits under this provision do not include benefits for Durable Medical Equipment or Prescription Drugs. For coverage of these items, please see the "Durable Medical Equipment" section and the "Prescription Drug Coverage" section.

Autism Spectrum Disorder Services Definitions:

"Autism Spectrum Disorder" means autism disorder, Asperger's syndrome, or pervasive development disorder not otherwise specified.

"Behavior Analyst" means a person certified by the Behavior Analyst Certification Board, Inc., or successor organization, as a board-certified Behavior Analyst and has been granted a license under Section 440.312, Wisconsin Statutes, to engage in the Practice of Behavior Analysis.

"Behavioral" means interactive therapies that target observable behaviors to build needed skills. These interactive therapies reduce problem behaviors using well-established principles of learning used to change socially important behaviors. The goal is building a range of communication, social and learning skills, as well as reducing challenging behaviors.

"Evidence-Based Therapy" means therapy, service, and treatment based upon medical and scientific evidence. Evidence-Based Therapy is determined to be a useful treatment or strategy. It is prescribed to improve the Member's condition or to achieve social, cognitive, communicative, self-care, or behavioral goals. These goals are

clearly defined within the Member's treatment plan. To be considered an efficacious treatment or strategy, the therapy must be designed to:

- Address cognitive, social, or Behavioral conditions associated with Autism Spectrum Disorders;
- Sustain and maximize gains made during Intensive-Level Services; or
- Improve an individual with Autism Spectrum Disorder's condition.

"Intensive-Level Services" means evidence-based Behavioral therapies designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social, and behavioral deficits linked with that disorder. These therapies must be directly based on, and related to, a Member's therapeutic goals and skills. These goals and skills are prescribed by a physician familiar with the Member. Intensive-Level Services may include evidence-based speech therapy and occupational therapy. These therapies are provided by a Qualified Therapist when such therapy is based on or related to a Member's therapeutic goals and skills and is concomitant with evidence based Behavioral therapy.

"Nonintensive-Level Services" means Evidence-Based Therapies that occur after the completion of treatment with Intensive-Level Services. These are designed to sustain and maximize gains made during treatment with Intensive-Level Services. They are also designed for an individual who has not and will not receive Intensive-Level Services, Evidence-Based Therapies that will improve the individual's condition.

"Practice of Behavior Analysis" means the design, use, and evaluation of systematic instructional and environmental modifications. These modifications are used to produce socially significant improvements in human behavior. These improvements include the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. This includes interventions based on scientific research and the direct observation and measurement of behavior and environment. Practice of Behavior Analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, marriage counseling, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

"Qualified Intensive-Level Professional" means an individual working under the Supervision of an Outpatient Mental Health Clinic who is a licensed treatment professional as defined in Section DHS 35.03(9g), Wis. Admin. Code. This professional has completed at least 2,080 hours of training, education, and experience including all of the following:

- 1,500 hours of supervised training. This training involves direct one-on-one work with individuals with Autism Spectrum Disorders using evidence-based, efficacious therapy models;
- Supervised experience with all of the following:
 - Working with families as part of a treatment team and ensuring treatment compliance;
 - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
 - Treating individuals with Autism Spectrum Disorders with a variety of Behavioral challenges;

- Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
- Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders; and
- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of Evidence-Based Therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

“Qualified Intensive-Level Provider” means an individual identified in Section 632.895(12m)(b)1. To 4., Wisconsin Statutes, acting within the scope of a currently valid state-issued license for psychiatry, psychology, or Behavior Analyst. It also means a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides evidence-based Behavioral therapy in accordance with this provision and Section 632.895(12m)(a) 3., Wisconsin Statutes. This individual has completed at least 2,080 hours of training, education, and experience that includes all of the following:

- 1,500 hours of supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using evidence-based, useful therapy models;
- Supervised experience with all of the following:
 - Working with families as the primary provider and ensuring treatment compliance;
 - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
 - Treating individuals with Autism Spectrum Disorders with a variety of Behavioral challenges;
 - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills;
 - Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders;
- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of Evidence-Based Therapy models. This coursework must be consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

“Qualified Paraprofessional” means an individual working under the active supervision of a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Provider and who complies with all of the following:

- Is at least 18 years of age;
- Obtains a high school diploma;
- Completes a criminal background check;
- Obtains at least 20 hours of training. This training includes subjects related to Autism Spectrum Disorders, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;
- Obtains at least 10 hours of training in the use of Behavioral Evidence-Based Therapy including the direct application of training techniques with an individual

- who has Autism Spectrum Disorder present;
- Receives regular, scheduled oversight by a Qualified Supervising Provider in implementing the treatment plan for the Member.

“Qualified Professional” means a professional acting under the Supervision of an Outpatient Mental Health Clinic certified under Section 51.038, Wisconsin Statutes, acting within the scope of a currently valid state-issued license and who provides Evidence-Based Therapy in accordance with this provision.

“Qualified Provider” means an individual acting within the scope of a currently valid state-issued license for psychiatry, psychology, or Behavior Analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides Evidence-Based Therapy in accordance with this provision.

“Qualified Supervising Provider” means a Qualified Intensive-Level Provider who has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals, and paraprofessionals.

“Qualified Therapist” means an individual who is either a speech-language pathologist or occupational therapist acting within the scope of a currently valid state-issued license and who provides Evidence-Based Therapy in accordance with this provision.

“Supervision of an Outpatient Mental Health Clinic” means an individual who meets the requirements of a Qualified Supervising Provider and who periodically reviews all treatment plans developed by Qualified Professionals for Members with Autism Spectrum Disorders.

“Waiver Program” means services provided by the Wisconsin Department of Health Services through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare and Medicaid Services.

Intensive-Level Services Benefit

Covered Services include evidence-based Behavioral Intensive-Level Services, the majority of which are provided to the Member when a parent or legal guardian is present and engaged in the therapy. The therapy must be prescribed by a physician and must meet all of the following requirements:

- Therapy must be based upon a treatment plan developed by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional that includes at least 20 hours per week over a six-month period of time of evidence-based Behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed, continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require the Member to be present and engaged in the intervention;
- Therapy must be implemented by Qualified Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals;

- Therapy must be provided in an environment that is most conducive to achieving the goals of the Member's treatment plan;
- Therapy must implement identified therapeutic goals developed by the team including training, consultation, participation in team meetings, and active involvement of the Member's family;
- Therapy must begin after a Member is two years of age and before he or she is nine years of age;
- Therapy must be provided by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional who directly observes the Member at least once every two months.

Progress must be assessed and documented throughout the course of treatment. We may, at Our option, request and review the Member's treatment plan and the summary of progress on a periodic basis.

Coverage for Intensive-Level Services will be provided for up to 48 months. Molina may credit against the required 48 months of Intensive-Level Services any previous Intensive-Level Services the Member may have received prior to enrolling under this product. Molina may require documentation, including medical records and treatment plans, to verify any evidence-based Behavioral therapy that the Member received for Autism Spectrum Disorders that was provided prior to the Member attaining nine years of age. Molina may consider any evidence-based Behavioral therapy that was provided to the Member for an average of 20 or more hours per week over a continuous six-month period to be Intensive-Level Services.

Travel time for Providers will not be included when calculating the number of hours of care provided each week. Benefits are not payable for separately billed travel time.

Benefits are also payable for charges of a Qualified Therapist when services are rendered concomitant with Intensive-Level evidence-based Behavioral therapy and all of the following:

- The Qualified Therapist provides Evidence-Based Therapy to the Member who has a primary diagnosis of an Autism Spectrum Disorder;
- The Member is actively receiving Behavioral services from a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional;
- The Qualified Therapist develops and implements a treatment plan consistent with their license.

Nonintensive-Level Services Benefit

Covered Services include evidence-based Nonintensive-Level Services, including direct or consultative services, that are provided to a Member by a Qualified Provider, Qualified Professional, Qualified Therapist, or Qualified Paraprofessional either after the completion of Intensive-Level Services to sustain and maximize gains made during Intensive-Level Services or provided to a Member who has not and will not receive Intensive-Level Services but for whom Nonintensive-Level Services will improve the Member's condition. Nonintensive-Level Services must meet all of the following requirements:

- Therapy must be based upon a treatment plan developed by a Qualified Provider, Qualified Professional, or Qualified Therapist that includes specific Evidence-Based Therapy goals that are clearly defined, directly observed, continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require the Member to be present and engaged in the intervention;
- Therapy must be implemented by a Qualified Provider, Qualified Professional, Qualified Therapist, or Qualified Paraprofessional;
- Therapy must be provided in an environment most conducive to achieving the goals of the Member's treatment plan;
- Therapy must implement identified therapeutic goals developed by the team including training, consultation, participation in team meetings, and active involvement of the Member's family.

Progress must be assessed and documented throughout the course of treatment. Molina may request and review the Member's treatment plan and the summary of progress on a periodic basis.

Travel time for Providers will not be included when calculating the number of hours of care provided each week. Benefits are not payable for separately billed travel time.

Transition to Nonintensive-Level Service

Molina will provide notice to the Member or the Member's authorized representative regarding a change in the Member's level of treatment. The notice will indicate the reason for transition that may include any of the following:

- The Member has received 48 cumulative months of Intensive-Level Services;
- The Member no longer requires Intensive-Level Services based on supporting documentation from a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Intensive-Level Professional;
- The Member is no longer receiving evidence-based Behavioral therapy for at least 20 hours per week over a six-month period of time.

Notice Requirement

The Member or the Member's authorized representative must notify Molina at any time in which such Member requires and qualifies for Intensive-Level Services but is unable to receive Intensive-Level Services for an extended period of time. The Member or the Member's authorized representative must indicate the specific reason(s) in which the applicable Member's family or caregiver is unable to comply with the Intensive-Level Services treatment plan. Reasons for requesting Intensive-Level Services to be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event, or any other reason that We determine to be acceptable.

We will not deny Intensive-Level Services provided to a Member for failing to maintain at least 20 hours per week of evidence-based Behavioral therapy over a six-month period of time when such Member or Member's authorized representative provides the notice required under this section or when the Member or Member's authorized representative can document that the failure to maintain at least 20 hours per week of evidence-based Behavioral therapy was due to waiting for Waiver Program services.

Non-Covered Services related to Autism Spectrum Disorder

Molina will not cover or pay for any expenses incurred for the following:

- Acupuncture
- Animal-based therapy, including hypnotherapy
- Auditory integration training
- Chelation therapy
- Child-care fees
- Claims that have been determined by Us to be fraudulent
- Costs for a facility or location or use of a facility or location when treatment, services, or Evidence-Based Therapy are provided outside of the Member's home
- Cranial sacral therapy
- Custodial care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Therapy, treatment, or services provided to a Member who is residing in a residential treatment center, inpatient treatment facility, or day treatment facility
- Treatment rendered by a parent or legal guardian who is otherwise considered a Qualified Provider, Qualified Supervising Provider, Qualified Therapist, Qualified Professional, or Qualified Paraprofessional when the treatment is rendered to his or her own children
- Travel time by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals

Cancer Treatment: Molina provides the following coverages for cancer care 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)
- Diagnostic screening, laboratory, and procedures
- 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 information)

Dental and Orthodontic Services: Dental and orthodontic services provided under this agreement must be Prior Authorized and are limited to the following:

- Dental services for radiation treatment
- Dental and Orthodontic services for cleft palate
- Services to treat Temporomandibular Joint Syndrome (TMJ) (Please refer to the Temporomandibular Joint Syndrome section of this Agreement)
- Dental services needed due to accidental injury

Hospital and ambulatory surgical center charges provided in conjunction with dental care, including anesthetics provided, are covered if any of the following apply:

- The Member is a child under the age of five
- The Member has a chronic disability
- The Member has a medical condition requiring hospitalization or general anesthesia for dental care

Molina does not provide pediatric dental services under this Agreement.

Diabetes Services: Molina covers the following diabetes-related services:

- Diabetes self-management training and education when provided by a Participating Provider
- Diabetic eye examinations (dilated retinal examinations)
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting
- Outpatient self-management training
- Preventive, routine foot care for Members with diabetes (including 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 (Type 2) screening
 - Screening for gestational diabetes
- Dietitian services
- Nutritional counseling

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

Dialysis Services: Molina covers acute and chronic dialysis services 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 24 hours a day, 7 days a week for Members. Members who think they are having an Emergency should call 911 right away and go to the closest Emergency facility. When receiving 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 the 24-Hour Nurse Advice Line toll-free or contact their PCP. 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 48 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, Post-Stabilization Services and other exceptions identified in this Agreement. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility.

If the Member refuses the transfer, additional services provided in the Non-Participating Provider facility, including Post-Stabilization Services, are not Covered Services. Non-Covered Services may not be entitled to Balance Billing protections and the provider may balance bill Members for these services. The Member will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of-Pocket.

Emergency Medical Transportation: Emergency Medical Transportation (ground and air ambulance), or 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.

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 and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aids: Molina covers hearing aids for a Member of any age if the hearing aid is required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness).

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Bone anchored hearing aids are medical/surgical Covered Services under this EOC only for Members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Covered Services for hearing services are limited to one hearing aid per ear every three years.

Benefits under this section also include hearing aids for Dependent children under 18 years of age, to the extent required under Wisconsin insurance law.

Home Healthcare: Molina covers home healthcare services if all of the following apply:

- Hospitalization or confinement in a skilled nursing facility would otherwise be required if home healthcare was not provided

- Necessary care and treatment are not available from the Member's immediate family or other persons living with the Member without causing undue hardship
- The home healthcare services are provided or coordinated by a licensed home healthcare agency or certified rehabilitation agency

Home healthcare services must be ordered by a physician and provided in the Member's home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse. Home healthcare agency services are provided on a part-time, intermittent basis to a Member confined to his or her home due to physical illness when Prior Authorized. Molina covers the following home healthcare services:

- In-home medical care services
- Home health aide services
- Medical social services
- 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 6 months in a 3-year period. Molina also covers respite care for up to 7 days per occurrence.

Inpatient Hospital Services: Members must have a Prior Authorization before receiving covered hospital services, except in the case of Emergency Services and Post-Stabilization Services. Post-Stabilization Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, provided the Member's coverage with Molina has not terminated and the Member has not waived Balance Billing protections pursuant to Federal Law. 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.

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 MRI with Prior Authorization. Molina can assist Members to 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.

Manipulative Treatment Services: We cover Medically Necessary manipulative treatment services. Manipulative treatment is the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment

and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function in the management of an identifiable neuromusculoskeletal condition.

Mental Health Services (Inpatient and Outpatient): Molina covers 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. The concurrent review authorization process applies to all involuntary admissions. Check MolinaMarketplace.com/WIGetCare or see the “Inpatient Concurrent Review” section of this Agreement for more information.

A mental disorder is a mental health condition identified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision (DSM5-TR). 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, 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 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
- Individual and group psychological therapy

Mental Health Parity and Addiction Equity Act: Molina complies with the 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.

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

- Office visits, including:
 - Associated supplies
 - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician’s office, an outpatient or an inpatient setting.

- 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.
- Sleep studies (Separate facility Cost Sharing may apply).

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 covers 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, 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: Molina covers pregnancy termination services to the extent required by the Affordable Care Act, federal law, and by any State Law

Note: Pregnancy termination services that are provided in an inpatient 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: <https://uspreventiveservicestaskforce.org>. Examples include screenings for:
 - Cervical cancer
 - Breast cancer including a mammogram every two Years or annually if ordered by a Provider, for women 45 years of age or older

- 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 (including blood lead tests) provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
- Preventive services and screenings provided in the comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. The Member should consult with their PCP to determine whether a specific service is preventive or diagnostic. 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, including treatment related to and procedures for implants for children under 18 years of age
- 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
- Podiatric devices to prevent or treat diabetes-related complications

Coverage is dependent on all 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). Covered Services are limited to a single purchase of each type of prosthetic device every 3 years.

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

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Facility: Molina covers 30 days per confinement 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

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 requires authorization for coverage of services, including inpatient and certain outpatient services. Molina covers the following outpatient care for treatment of substance use disorder:

- Short-term residential programs
- Day-treatment programs
- Detoxification

- Individual and group substance use disorder counseling
- Individual substance use disorder evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs)

Outpatient care for treatment of substance use disorder does not include therapy or counseling for any of the following: career, marriage, divorce, parental, job, treatment or testing related to autistic spectrum disorder, learning disabilities, and mental disabilities.

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:

- Anesthesia
- Antineoplastic drugs
- Discharge planning
- Operating and recovery rooms

Outpatient surgery services provided in any of the following locations:

- Outpatient or ambulatory surgical 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.

Temporomandibular Joint Syndrome ("TMJ") Services: Molina covers services to treat temporomandibular joint syndrome if all the following conditions apply:

- The condition is caused by a congenital, developmental or acquired deformity, disease or injury
- Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction

Covered Services for TMJ are limited to:

- Medically Necessary medical non-surgical treatment of TMJ, including coverage for prescribed intraoral splint therapy devices;
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed

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 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.

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

Pediatric Vision Services: 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.

Adult Routine Vision Services: Adult routine vision services are available on some plans. Refer to the Schedule of Benefits to see if these services are covered on your Plan. When covered, these benefits include the following vision services for Members age 19 and older when provided by a Participating Provider:

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

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 pharmacies in Molina's networks. Covered drugs include over-the-counter (OTC) and prescription drugs as listed on the Formulary. 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 networks. 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. To find network pharmacies, please visit MolinaMarketplace.com. 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 coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on MolinaMarketplace.com. 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, their representative, or a Prescriber to request clinically appropriate drugs that are not on the Formulary. They may request coverage for drugs that have step therapy requirements or other restrictions under the Plan benefit that have not been met. Members, their representative or Prescribers may contact Molina's Pharmacy Department to request a Formulary exception.

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's health condition that may seriously jeopardize their life, health, or ability to regain maximum function, or when the Member is undergoing a current course of treatment using a non-formulary drug. Trials of pharmaceutical samples from a Prescriber or a drug manufacturer will not be considered as current treatment.

Molina will notify the Member or their representative, and 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 or their representative and the 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, their representative, or Prescriber can appeal Molina's decision. The Prescriber may request to talk to Molina reviewers about the denial.

If an internal appeal of the original coverage determination is requested, Molina will notify the Member, their representative, and the Prescriber, of the internal appeal 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.

The Member or their representative, or the Prescriber may also request that an Independent Review Organization (IRO) review Molina's internal appeal decision. The member or their representative, and the Prescriber, will be notified 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, Preventive Drugs through Brand and Generic Specialty Drugs, based on how well they improve health and their value

compared to similar treatments. The Schedule of Benefits shows Member Cost Share for a one-month supply based on these tiers.

Below are some details about which drugs are on which tiers.

Drug Tier	Description
Preventive Drugs	Nationally recognized preventive service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with \$0 Cost Sharing; additional drugs with \$0 Cost Sharing where applicable.
Preferred Generic Drugs	Preferred generic drugs; lowest Cost Sharing.
Preferred Brand Drugs	Preferred brand-name drugs; higher Cost Sharing than preferred generic drugs.
Non-Preferred Drugs	Non-preferred brand-name and generic drugs; higher Cost Sharing than preferred brand-name and generic drugs used to treat the same conditions.
Specialty Drugs	Specialty drugs (brand-name and generic); Drugs that require special handling, complex counseling or monitoring, limited distribution, or other special pharmacy requirements. 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 a network specialty pharmacy.
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 the Non-Preferred Brand and Generic Drugs Tier cost share for non-specialty products or the Brand and Generic Specialty Drugs Tier cost share for Specialty products. Please note, for non-formulary 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.

Site of Care for Provider-administered Drugs Required Program: For Provider-administered drugs that require Prior Authorization, when coverage criteria are met for the medication, a site of care policy is used to determine the medical necessity of the requested site of care. Molina covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be medically necessary. To review the site of care policy, please visit [MolinaMarketplace.com](https://www.molinahealthplan.com/Marketplace).

Molina will conduct peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina will offer the ordering Provider help in identifying an in-network infusion center, physician office, or home infusion service, and will help the Member coordinate and transition through case management.

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.

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, supplies, 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. The cost sharing amounts as listed on your Schedule of Benefits apply per purchase or rental period. 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 MolinaMarketplace.com, or contact Customer Support for more coverage information.

Diabetic Supplies: Molina covers diabetic supplies on the Formulary such as insulin syringes, insulin infusion pumps (limited to one pump per calendar year), 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: short 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 site 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 the Brand and Generic Specialty Drugs Tier under the pharmacy benefit. Certain anti-cancer drugs are covered under a partial fill program. Network pharmacies may dispense newly started anti-cancer drugs half a month's supply at a time for the first several fills until Members are stable on the drug and dose.

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 the Preventive Drugs, Preferred Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand and Generic Drugs Tiers. Eligible drugs are marked "MAIL" on the Formulary. Formulary drugs will be mailed to a Member within 10 days of 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. Brand and Generic Specialty Drugs Tier drugs are not eligible for 90-day supply programs like Mail Order, though most Specialty medications will be shipped to the Member directly. Refer to the MolinaMarketplace.com 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
- Gene therapy
- Experimental and Investigational drugs
- Weight loss drugs, or diabetic drugs when used off-label to lose weight instead of treating diabetes.

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 equipment and services are excluded from coverage under this Agreement. These exclusions apply to all services that would otherwise be covered under this Agreement regardless of whether the services are within the scope of a Provider's license, except where expressly stated otherwise in this Section, or where otherwise required by State law. This is not an exhaustive list of services that are excluded from coverage under this Plan. Please contact Molina Customer Support for questions regarding exclusions.

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.

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.

Digital Health and Digital Therapeutics: Mobile applications, software, or hardware devices marketed as digital therapeutics to prevent, manage, or treat medical disorders or behavioral conditions are not covered. This does not apply to formulary continuous glucose monitors or covered insulin pump devices, which are considered durable medical equipment, and are subject to Prior Authorization.

Dietitian: A service of a Dietitian is not a covered service except as shown in the Hospice Care benefits of this Agreement.

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 Drugs: 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.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Most gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Molina covers limited gene therapy, cell therapy, and cell-based gene therapy, services in accordance with Molina's medical policies and subject to Prior Authorization.

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.

Infertility Services: Molina does not cover infertility services and supplies, including insemination and conception by artificial means, such as: ovum transplants, gamete

intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

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 Condoms: Male condoms are not covered except those on formulary for women's health preventative services.

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.

Reconstructive Surgery: The following reconstructive surgery services are not covered:

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

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
- 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 covered. This exclusion does not apply to preventive foot care for Members receiving benefits as described under the Diabetes Services section.

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 Appeals and Grievances section for information about denied requests for Experimental or Investigational services.

Services Provided Outside the Service Area: Except as otherwise provided in this Agreement, 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. 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 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 will 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.

Vision Care Services: Molina does not cover the following:

- Eye exercises, visual training, orthoptics, sensory integration therapy
- Radial keratotomy, laser surgeries, and other refractive keratoplasties

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 Member or 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. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, Molina will pay the Provider of service within 30 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements. The receipt date of a claim is the date Molina receives either written or electronic notice of the claim.

Molina Payment: Some Participating Providers receive a flat amount for each month that a Member is under their care, whether they see the Participating Provider or not. Some Providers work on a fee-for-service basis, which means they receive payment for each service they perform. Some Providers may receive incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in authorization denials or under-utilization. For more

information about how Providers are paid, Members may call Customer Support. Members may also call a Provider's office or medical group for this information.

Member Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was pre-approved or does not require pre-approval, Molina will repay the Member. The Member must submit the claim for reimbursement within 12 months from the date they made the payment.

For covered medical services, 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.

For covered prescription drugs, Members must complete a Reimbursement Form found in the Forms section of MolinaMarketplace.com. Members must include a copy of the prescription label and pharmacy receipt when submitting the request form to the address as instructed on the form. After the Member's request for reimbursement is received, it will be processed as a claim under their coverage. The Member will receive a response within 30 calendar days. If the claim is accepted, a reimbursement check will be mailed to the Member. If the claim is denied, the Member will receive 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 not a 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 of 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 is 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.

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.

Changes in Premiums and Cost Sharing: Any change to this Agreement, including, but not limited to, changes in Premiums, Covered Services, Deductible, Copayment, Coinsurance and OOPM amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina.

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 on the basis of pre-existing health conditions, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity, or genetic information.

This Plan does not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available

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 at 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 on 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 three (3) years 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 three (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.

Automobile Accident Related Injuries: Molina does not exclude coverage for automobile accident related injuries, except as permitted by State Law.

Illegal Occupation or Criminal Activity: Molina is not liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member's being engaged in an illegal occupation or other willful criminal activity.

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 you 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. Rewards and program benefits are available for redemption only while the Subscriber or eligible Dependent is currently enrolled with a Molina marketplace health plan. For more information, please contact Customer Support.

COMPLAINTS

For a problem with any Molina Healthcare services, Molina wants to help fix it.

Filing a Complaint

- Members or their Authorized Representative may file by phone by calling Molina Customer Support at the number shown on the Welcome page of this Agreement.
- Members can also submit a Grievance in writing, along with any supporting materials by mail to following the Molina address or fax number shown on the Welcome page of this Agreement:

**Molina Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422**

- Members can also submit a Grievance in writing to the Wisconsin Office of the Commissioner of Insurance at:

**OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
P.O. BOX 7873
MADISON, WISCONSIN 53707-7873**

- Members may also call **1 (800) 236-8517** (outside Madison) or **1 (608) 266-0103** (in Madison) or **7-1-1** (TTY) and request a complaint form. The Complaint Form is also available at <https://oci.wi.gov/Documents/OCIForms/51-005forprint.pdf>. Members may e-mail them at: **ocicomplaints@wisconsin.gov**.

Grievances (Internal Appeals and External Appeals)

Definitions for This “Grievance (Internal Appeals and External Appeals)” Section

“Adverse Benefit Determination” means: any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

“Appeal” means a Member’s, or Authorized Representative’s, written request for review of an Adverse Benefit Determination.

“Authorized Representative” means an individual who is authorized to act on a Member’s behalf with respect to a Grievance/Appeal either by law or in accordance with Molina’s processes.

“Expedited Grievance” means a Grievance or Appeal where the standard resolution process may include any of the following:

- Serious jeopardy to your life or health (or the life or health of your unborn child) or your ability to regain maximum function; or
- In the opinion of the treating physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or
- Is determined to be an expedited Grievance or Appeal by the treating physician.

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

“Complaint” means any dissatisfaction with Molina that is expressed verbally to Molina by a Member or their Authorized Representative that does not relate to an Adverse Benefit Determination.

“Grievance” means any dissatisfaction with Molina that is expressed in writing to Molina by a Member or their Authorized Representative that does not relate to an Adverse Benefit Determination.

“Grievance Panel” means a group of people responsible for the investigation and final resolution of each Grievance/Appeal.

“Post-Service” means an Adverse Benefit Determination has been rendered for a service that has already been provided.

“Pre-Service” means an Adverse Benefit Determination was rendered and the requested service has not been provided.

Filing a Complaint

Members or their Authorized Representative may file a Complaint by phone by calling Molina Customer Support, toll free, at the number listed on the Welcome page of this Agreement.

1. Molina will acknowledge the complaint during the intake phone call at Molina’s Customer Support Center.
2. Molina will research and resolve your complaint within 30 calendar days of receipt.
3. Your resolution will be communicated to you by phone or in writing if Molina is unable to reach you by phone.

Filing a Grievance

Members or their Authorized Representative can submit a grievance in writing, along with any supporting materials, by mail, email or fax to the Molina address or fax number shown on the Welcome page of this Agreement. Emailed grievances can be submitted to WIMemberAppeals@MolinaHealthCare.com.

1. Molina will acknowledge receipt of the Grievance/Appeal in writing within five business days of receiving it. If the Member’s Authorized Representative filed the Grievance on their behalf, Molina will also provide a notice that health care information or medical records may be disclosed only if permitted by law. Molina will also include an informed consent form.
2. Molina will notify the Member and their Authorized Representative (if applicable) in writing of the time and place of the Grievance Panel meeting at least seven calendar days in advance. The Member or their Authorized Representative have the right to appear before the Grievance Panel in person or by telephone to present written or oral information concerning the Grievance/Appeal. Members may also submit written questions to the persons responsible for making the determination that resulted in the denial or determination of benefits or a decision to disenroll a Member.
3. Except if the Grievance/Appeal is an Expedited Grievance/Appeal as described in paragraph 4 below, Molina will notify Members of the disposition of the Grievance/Appeal within 30 calendar days of receipt, unless Molina is not able to resolve the Grievance within 30 calendar days. In the event Molina is unable to make a determination within the initial 30 calendar days of receipt of the

Grievance, Molina may extend the determination period for an additional 30 calendar days. If an extension is required, Molina will notify the Member in writing:

- a. That Molina has not resolved the Grievance/Appeal;
 - b. Of the reasons for the extension; and
 - c. When resolution may be expected.
4. If a Grievance/Appeal involves an Expedited Grievance, Molina will resolve such Grievance within 72 hours after receipt. Members may request an Expedited Grievance by calling or faxing Molina Customer Support at the number shown on the Welcome page of this Agreement.
 5. Members may request free of charge any documents that Molina used to make a decision.
 6. Molina will require a written expression of authorization for representation from any person acting on a Member's behalf unless any of the following applies:
 - The person acting on the Member's behalf is authorized by law to act on behalf of the Member
 - The Member is unable to give consent and the person acting on their behalf is a spouse, family member or the treating provider
 - The Grievance is an Expedited Grievance and the person acting on the Member's behalf represents that the Member has verbally given him/her authorization to represent the Member

Molina shall process a Grievance/Appeal without requiring written authorization unless, in the acknowledgement of receipt of a Grievance/Appeal to the Authorized Representative, Molina clearly and prominently does all of the following:

- Notifies the person acting on the Member's behalf that, unless any of the exceptions listed above apply, the Grievance will not be processed until Molina receives a written authorization
- Requests written authorization from the person acting on the Member's behalf
- Provides the person acting on the Member's behalf a form the Member may use to give written authorization. The Member may, but is not required to, use the Molina form to give written authorization. Molina will accept a written expression of authorization in any form, language or format

Filing an External Appeal

After Members have exhausted the Grievance (internal appeal) rights provided by Molina, they have the right to request an external/independent review of an Adverse Benefit Determination. Members (or their Authorized Representative) may file a written request for an external review. The Member's notice of Adverse Benefit Determination and/or Final Adverse Benefit Determination describes the process to follow if they wish to pursue an external appeal.

Members must submit their request for external review within four months of the date they receive the notice of Adverse Benefit Determination or Final Adverse Benefit Determination.

Members can request an external appeal at **1 (888) 866-6205**, online at www.externalappeal.com, or by mail at:

**HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534**

If a Member has any questions or concerns during the external appeal process, they (or their Authorized Representative) can call the toll-free number **1 (888) 866-6205**. Members (or their Authorized Representative) can submit additional written comments to the external reviewer at the mailing address above. If any additional information is submitted, it will be shared with Molina in order to give Molina an opportunity to reconsider the denial.

Request for expedited external appeal – Members (or their Authorized Representative) may make a written or oral request for an expedited external appeal with the external reviewer when they receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an Expedited Grievance would seriously jeopardize their life or health or would jeopardize their ability to regain maximum function and the Member has filed a request for an Expedited Grievance; or
- A Final Adverse Benefit Determination, if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize their life or health or would jeopardize their ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Member received services, but has not been discharged from a facility.
- An Adverse Benefit Determination that relates to Experimental or Investigational treatment, if the treating physician certified that the recommended or requested health care service, supply, or treatment would be significantly less effective if not promptly initiated.

In expedited external appeal situations, requests for expedited review can be initiated by calling MAXIMUS Federal Services at the number shown above, or by faxing or mailing the request to MAXIMUS at the fax number or address shown above.

Additionally, at the Member's request, Molina can send copies of the actual benefit provision, and will provide a copy at no charge, of the actual benefit, clinical guidelines or clinical criteria used to make the determination upon receipt of a request from the Member. A request can be made by calling Molina Customer Support at the number shown on the Welcome page of this Agreement.

Filing a Complaint with the Office of the Commissioner of Insurance

Members may resolve their problem by taking the steps outlined above. Members may also file a complaint with the Wisconsin **OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)**. The **OCI** is a state agency that enforces Wisconsin's insurance laws. Members may contact the **OCI** by writing to the OCI address shown above.

Members may also call the **OCI** Complaints Department at the numbers shown above to request a Complaint Form. The Complaint Form is also available at **oci.wi.gov**. Members may e-mail the OCI at: **ocicomplaints@wisconsin.gov**.

General Rules and Information

General rules regarding Molina's Complaints, Grievances (Internal Appeals) and External Appeals Process include the following:

- Molina will offer to speak with a Member by telephone. Appropriate arrangement will be made to allow telephone conferencing to be held at Molina's administrative offices. Molina will make these telephone arrangements with no additional charge to the Member.
- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.
- Molina will provide Members with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when the initial Adverse Benefit Determination was made. A "full and fair" review process requires Molina to send any new medical information directly to the Member so they have an opportunity to review the file.

Your Extended Family:

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 <https://www.hhs.gov/ocr/complaints/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.

ATTENTION: Aids and services for people with disabilities, like documents in braille and large print, are also available. If you need help in your language call Member Services located on back of your ID card. (TTY: 711). These services are free of charge.

ATENCIÓN: Si necesita ayuda en su idioma llame a Servicios para Miembros. El número está en el reverso de su tarjeta de identificación de miembro. (TTY: 711). También hay disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y letra grande. Estos servicios son gratuitos. (Spanish)

. تنبيه: إذا كنت بحاجة إلى مساعدة في لغتك ، فاتصل ، بخدمات الأعضاء. الرقم موجود على ظهر بطاقة هوية العضو الخاصة بك
(Arabic). (الهاتف النصي: 711). تتوفر أيضا مساعدات وخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل والطباعة الكبيرة. هذه الخدمات مجانية

ՈՒՇԱԿՈՒՄԻՑՈՒՄ: Եթե ձեր լեզվով օգնության կարիք ունեք, գտնվող Member Services: Համարը գտնվում է Ձեր Member ID քարտի ետևի մասում: (TTY: 711):

Առկա են նաեւ հաշմանդամություն ունեցող անձանց համար նախատեսված օգնության միջոցներ եւ ծառայություններ, ինչպես բրայլի եւ մեծ տպաքանակի փաստաթղթեր: Այս ծառայությունները անվճար են: (Armenian)

ការយកចិត្តទុកដាក់ដល់នាយសីសសេវាកម្មសម្រាប់ជនពិការភ្នែកឯកសារក្នុងអក្សរធំឬនាបន្លំនិងសេវាផ្សេងៗទៀត។

ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការហៅការងាររបស់អ្នកជាសមាជិកសេវាកម្មដែលមានទីតាំងនៅខាងក្រោយអត្តសញ្ញាណប័ណ្ណរបស់អ្នក, (TTY: ៧១១), សេវាកម្មទាំងនេះដោយមិនគិតថ្លៃ, (Cambodian)

注意:如果您需要语言方面的帮助, 请致电会员服务部。该号码位于您的会员 ID 卡背面。(TTY: 711)。
还为残疾人提供辅助工具和服务, 如盲文和大字体文件。这些服务是免费的。(Chinese Simplified)

توجه: کمک ها و خدمات برای افراد معلول, مانند اسناد بریل
. و چاپ بزرگ نیز در دسترس هستند. در صورت نیاز به کمک در زبان خود با خدمات عضو واقع در پشت کارت شناسایی خود تماس بگیرید
(Farsi). این خدمات رایگان هستند. (TTY: 711)

ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता है, तो सदस्य सेवाओं को कॉल करें। नंबर आपके सदस्य आईडी कार्ड के पीछे है। (TTY: 711)
। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज, भी उपलब्ध हैं। ये सेवाएं नि: शुल्क हैं। (Hindi)

XIM: Yog koj xav tau kev pab los ntawm koj cov kev pab. Tus naj npawb nyob sab nraum qab ntawm koj tus ID card. (TTY: 711).

Aids thiab kev pab rau cov neeg uas muaj mob xiam oob qhab, xws li cov ntaub ntawv nyob rau hauv braille thiab loj print, kuj muaj. Cov kev pab no yog pab dawb xwb. (Hmong)

ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, rufen Sie den Mitgliederservice an. Die Nummer finden Sie auf der Rückseite Ihres Mitgliedsausweises. (TTY: 711).

Hilfsmittel und Dienstleistungen für Menschen mit Behinderungen, wie Dokumente in Blindenschrift und Großdruck, sind ebenfalls verfügbar. Diese Dienstleistungen sind kostenlos. (German)

注意:あなたの言語で助けが必要な場合は、メンバーサービスに電話してください。番号は会員証の裏面に記載されています。(TTY: 711)。
点字や大活字の書類など、障害者のための援助やサービスも利用できます。これらのサービスは無料です。(Japanese)

주의: 귀하의 언어로 도움이 필요하면 회원 서비스에 전화하십시오. 이 번호는 가입자 ID 카드 뒷면에 있습니다. (TTY: 711)입니다.
점자 및 큰 활자로 된 문서와 같은 장애인을 위한 보조 및 서비스도 제공됩니다. 이러한 서비스는 무료입니다. (Korean)

ຂ້ອນລະວັງ: Aids ແລະການບໍລິການສໍາລັບຄົນພິການ, ຄຸ້ນດຽວກັບເອກະສານໃນ braille ແລະການພິມຂະໜາດໃຫຍ່, ຍັງມີ.
ຖ້າ ທ່ານ ຕ້ອງ ການ ຄວາມ ຊ່ວຍ ເຫຼືອ ໃນ ພາ ສາ ຂອງ ທ່ານ call Member Services ທີ່ ຕັ້ງ ຢູ່ ທາງ ຫລັງ ຂອງ ບັດ ID ຂອງ
ທ່ານ. (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ. (Loatian)

attention: aids caux services bun mienh caux disabilities oix documents yie braille caux large print naaic yaac available da'faanh meih oix zuqc tengx yie meih nyei
language heuc member services located zieqc back of meih nyei yie cie (tty: 711) these services naaic free of charge. (Mien)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ ਮੈਂਬਰ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਹੈ। (TTY: 711)।
ਅਪਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। (Punjabi)

ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните в службу поддержки. Номер указан на обратной стороне вашей идентификационной карты. (Телетайп: 711).

Также доступны вспомогательные средства и услуги для людей с ограниченными возможностями, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Эти услуги бесплатны. (Russian)

ATTENTION: Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Kung kailangan mo ng tulong sa iyong wika tumawag sa Member Services na matatagpuan sa likod ng iyong ID card. (TTY: 711). Ang mga serbisyo ito ay libre. (Tagalog)

ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโปรดติดต่อฝ่ายบริการสมาชิก หมายเลขจะอยู่ด้านหลังบัตรประจำตัวสมาชิกของคุณ (TTY: 711)
นอกจากนี้ยังมีบริการช่วยเหลือสำหรับคนพิการ เช่น เอกสารอักษรเบรลล์และสิ่งพิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่าย (Thai)

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711).
Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711).
Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)