2021 |
Agreement and Individual Evidence of Coverage

Molina Healthcare of Texas, Inc Marketplace

Molina Healthcare of Texas, Inc.
5605 MacArthur Blvd, Suite 400
Irving, TX 75038
1 (888) 560-2025
www.MolinaMarketplace.com

MOLINA® HEALTHCARE

Visit us a MolinaMarketplace.com

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

Notice of Rights: Molina Healthcare, a health maintenance organization (HMO) plan provides no benefits for services a Member receives from out-of-network providers, with specific exceptions as described in your evidence of coverage and below. A Member has the right to an adequate network of in-network physicians and providers (known as network physicians and providers). If a Member believes that the network is inadequate, the Member may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html. If Molina approves a Referral for out-of-network services because no network physician or provider is available, or if the Member has received out-of-network emergency care, Molina must, in most cases, resolve the out-of-network physician's or provider's bill so that the Member only has to pay any applicable in-network copayment amounts. A Member may obtain a current directory of network physicians and providers at the following website: MolinaMarketplace.com or by calling 1 (888) 560-2025 for assistance in finding available network physicians and providers. If the Member relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if a Member presents a copy of the inaccurate directory information to Molina, dated not more than 30 days before the Member received the service.

Premium Increase Notice: Premium may be increased upon the Renewal Date of this Agreement; this Agreement may be subject to non- renewal for Dependents surpassing the maximum Dependent age limit. In the event of a rate increase, We will provide written notice of the increase at least 60 days before the increase takes effect, which will include the dollar amount of the premium before and after the change, and the percentage change between the two.

ADDITIONAL NOTICE: THIS AGREEMENT IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

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

YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Molina Healthcare of Texas

To get information or file a complaint with your insurance company or HMO:

Call: Customer Support **at** 1 (888) 560-2025
Toll-free: 1 (888) 560-2025
Online: MolinaMarketplace.com
Mail: 5605 MacArthur Blvd, Suite 400, Irving, TX 75038

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Molina Healthcare of Texas

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Customer Support 1 (888) 560-2025
Teléfono gratuito: 1 (888) 560-2025
En línea: MolinaMarketplace.com
Dirección postal: 5605 MacArthur Blvd, Suite 400, Irving, TX 75038

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

MOLINA REFERENCE GUIDE

Service	Need	Where to Go
Emergency Services	• Emergencies and Immediate Care	Call 911
Getting Care	• Urgent Care • Minor Illnesses • Minor Injuries • Virtual Care • Physicals and check-ups • Preventive care • Immunizations (shots)	Call your Doctor Urgent Care Centers Find a provider or urgent care center MolinaHealthcare.com/ProviderSearch 1 (888) 560-2025 24-Hour Nurse Advice Line 1 (888) 275-8750 (English) 1 (866) 648-3537 (Spanish) TTY (for the hearing impaired): 711 A nurse is available 24/7
Online Access	• Find or change your doctor • Update your contact information • Request an ID card • Get health care reminders • Track office visits	Go to MyMolina.com and sign up Download the Molina Mobile App Visit MolniaMarketplace.com Visit MolinaHealthcare.com/ProviderSearch
Plan Details	• Answers about your plan, programs and services • Answers about prescription drugs • ID card issues • Help with your visits • Prenatal care • Well-infant visits • Payment Questions	Molina Customer Support Center Toll-Free: (888) 560-2025 TTY/TDD: 711 MolinaPayment.com.

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

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Evidence of Coverage Issuance: This Molina Healthcare of Texas, Inc. Agreement and Individual Evidence of Coverage (also called the "Agreement") is issued by Molina Healthcare of Texas, 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 Exchange 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. All documents are attached to the Evidence of Coverage as required by state law.

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

Welcome to Molina Healthcare!

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 sending you this 2021 Molina of Texas Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

- How You can get services through Molina
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Molina
- How to contact Molina

Please read this Agreement carefully. Inside is information about a wide range of health needs and services provided. Contact us if you have questions or concerns, or need details about:

- Getting an interpreter
- Check on Prior Authorization status
- Choose a Primary Care Provider (PCP)
- Paying a premium or for a Covered Service
- Make an appointment
- Your benefits of your Plan

You can reach Customer Support at MolinaMarketplace.com or 1 (888) 560-2025.

We look forward to serving you!

DEFINITIONS

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

Adverse Determination: A determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

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. Services obtained from a Participating Provider: This means the contracted rate for such Covered Services. Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of:

1) Molina's median contracted rate for such service(s),
2) 100% of the published Medicare rate for such service(s), or
3) Molina's usual and customary method for determining payment for such service(s).

All other Covered Services received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina's median contracted rate for such service(s), 100% of the published Medicare rate for such service(s), Molina's usual and customary rate for such service(s), or 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 copayments, Molina pays 100% of the costs of Covered Services. 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 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 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. Once the Cost Sharing for two or more Member's family adds up to the family OOPM amount, Molina will pay 100% of the charges for Covered Services for the rest of the calendar year for the Member and every Member of their family.

Balance Bill or Balance Billing: When a Provider bills a Member for the difference between the Provider's charge and the Allowed Amount. A Molina Participating Provider may not balance bill you 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.

Complications of Pregnancy: A condition due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.

Copayment: A fixed or percentage 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 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 supplies and prescription drugs, that Members are entitled to receive from Molina under this Plan.

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

Drug Formulary or Formulary: A list of drugs this Molina Plan covers. The Drug Formulary 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: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

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

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

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

Essential Health Benefits or **EHB:** 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.

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

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

Medically Necessary or **Medical Necessity:** 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 We have 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 minor child who, as of the beginning of the plan year, has not attained the age of 21. In which case, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this Agreement but will not be a Member.

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

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

Molina Healthcare of Texas Agreement and Individual Evidence of Coverage ("**Agreement**"): This document, which has information about coverage under this Plan.

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

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

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

Primary Care Provider: who has identified their primary professional designation to Us as a "PCP", and is the doctor who takes care of Your health care needs. Your Primary Care Doctor has Your medical history. Your Primary Care Doctor makes sure You get needed health care services. A Primary Care Doctor may refer You to a Specialist Physician for other services. A Primary Care Doctor includes, but is not limited to, one of the following types of doctors:

- Family or general practice doctor who usually can see the whole family.
- Internal medicine doctor, who usually only see adults and children 14 years or older.
- Pediatrician, who see children from newborn to age 18 or 21.
- Obstetrician and Gynecologist
- A Specialist for a Member with a chronic, disabling, or life-threatening illness

Prior Authorization: Approval from Molina that may be required before a Member gets a service or fills a prescription in order for the service or prescription to be 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 and applicable Member Cost Sharing.

Service Area The geographic area where Molina has been authorized by the State to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace, and provide benefits through approved individual health plans sold through the Marketplace.

Specialist: A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

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

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

ELIGIBILITY AND ENROLLMENT

An individual must be enrolled as a Member of this Plan for Covered Services to be available. To enroll and become a Member, an individual must meet all eligibility requirements established by the Marketplace. Molina requires that the Subscriber lives, resides, or works in the service to be enrolled in the product. With the exception of Emergency Services, qualified dependents who reside outside the Molina Service Area must receive Covered Services from Participating Providers who are located in the Molina Service Area. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber.

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

Special Enrollment Period: If an individual does not enroll during an Open Enrollment Period, they may be able to enroll during a Special Enrollment Period. To qualify for a Special Enrollment Period, an individual must have had certain life events established by the Marketplace. The Effective Date of 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 for individuals under the age of 21 at the beginning of the plan year, and a parent or legal guardian applies on behalf of the child. For more information, please contact the Marketplace.

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

- **Spouse**: The individual lawfully married to the Subscriber under State Law.
- **Child or Children**: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren) and any child for whom the Subscriber must provide medical support by a medical support order. Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- **Subscriber's grandchildren** qualify as Dependents of the Subscriber only if the grandchild is unmarried, younger than 25 years of age and a dependent of the Subscriber for federal income tax purposes at the time application for coverage is made. Once enrolled coverage for a grandchild of the Subscriber will not be terminated solely because the grandchild is no longer a dependent of the Subscriber for federal income tax purposes.
- **Child with a Disability**: A child who reaches the age of 26 is eligible to continue enrollment 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 of any age if they are permanently and totally disabled. A child may remain covered by Molina Healthcare 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, Molina, and State Law.

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

Spouse: 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 the Member's 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
- The child becomes a Dependent through marriage, birth, placement in foster care, adoption, placement for adoption, child support, or other court order (a child covered through a court order and who lives outside of the service area will receive the same benefits)
- The Child gains status as a citizen, national, or lawfully present individual
- The Child permanently moves into the service area.

Newborn Child: A newborn child of a Subscriber is eligible as a Dependent at birth. A newborn is initially covered for 31 days, including the date of birth. A newborn child is eligible to continue enrollment if they enrolled with Molina within 60 days. Please note, claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Annual Out-of-Pocket Maximum. However, if an enrollment file is received for the newborn during the first 31 days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Annual Out-of-Pocket Maximum (i.e. not under the enrolled mother's Annual Out-of-Pocket Maximum).

Adopted Child: If You adopt a child or a child is placed with You for adoption, then the child is eligible for coverage under this Agreement. The child can be added to this Agreement during the open enrollment period, within 60 days of the child's adoption or within 60 days of the date the child has become the subject for a suit for adoption or placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier. The child's coverage shall be effective on the date of the child has become the subject for a suit for adoption or placement for adoption or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws. The date the child has become the subject for a suit for adoption or placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier.

Foster Child: A newly foster child or child placed with the Member or the Member's Spouse for foster care is covered from whichever date is earlier:

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

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

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

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

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

- At 11:59 p.m. on the last day of the calendar year that the Dependent child attains age 26, unless the child has a disability and meets specified criteria (see Child with a Disability).
- The date the Dependent Spouse enters a final decree of divorce, annulment or dissolution of marriage.
- The date the Dependent Domestic Partner enters a termination of the domestic partnership from the Subscriber.
- For Child-Only Coverage, at 11:59 p.m. 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 10 days before the effective date on which the Member will lose eligibility. The Member can appeal the loss of eligibility.

PREMIUM PAYMENT

To establish and maintain coverage under this Plan, Molina requires Members to make monthly payments in consideration, known as "Premium Payments" or "Premiums." Premium Payment for the upcoming coverage month is due no later than the 25th day of that 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 Exchange to determine if they are eligible. If the Subscriber is eligible for a 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 Molina Marketplace website or contact Member Services for further information. Payments are not accepted at Molina office locations.

Late Payment Notice: Molina will send written notification to the Subscriber's address of record if full payment of the Premium is not received on or before the Due Date. This notification will inform the Subscriber of the amount owed, include a statement that Molina will terminate the Agreement for nonpayment if the full amount owed is not received prior to the expiration of the grace period as described in the Late 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 short period after a Member's Premium Payment is due and has not been paid in full. If a Subscriber hasn't made payment, they may do so during the Grace Period and avoid losing their coverage. The length of 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 advance payments of the premium tax credit (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 zone 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 30 days consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an advance payment of the premium tax credit (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 zone on the last day of the month prior to the beginning of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

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

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

Re-enrollment After Termination for Non-Payment: If a Subscriber is terminated for non-payment of Premium and enrolls with Molina during Open Enrollment or a Special Enrollment Period in the following plan year, Molina may require that a Subscriber pay any past due Premiums. Molina will also require first month's Premium payment 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 Exchange 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 covered with Molina. Coverage for a former Member ends at 11:59 p.m. on the day before the termination date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date. Except in the case of fraud or intentional misrepresentation of material fact, if a Member's coverage is terminated, any Premium payments received on account of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within 30 days. Molina and its Providers will not have any further liability under this Plan. In the case of fraud, Molina may retain portions of this amount in order to recover losses due to the fraud.

Molina may terminate or non-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 Exchange 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 Exchange and Molina. The Exchange will send the Member notification of loss of eligibility. Molina will also send the Member written notification when informed that the Member no longer resides within the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to the Member. The Member may request an earlier termination effective date.

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

Fraud or Intentional Misrepresentation of material fact: Member has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with coverage. Molina will send written notification of termination, and the Member's coverage will end at 11:59 p.m. on the 30th day from the date notification is sent. If the Member has committed Fraud or Intentional Misrepresentation of material fact, 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 Exchange. The Exchange 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;
- The 24th week of pregnancy through the postpartum period and a follow-up checkup within the six-week period after delivery; 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.
- If the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.
- 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. The member will be responsible for associated Cost Share.

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:

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

ACCESSING CARE

For an Emergency, call 911. For an Emergency, Members may call an Ambulance or go to any hospital emergency room, even if it is a Non-Participating Provider or outside of the Service Area.
24-Hour Nurse Advice Line: Registered Nurses are available 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

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 Annual Out-of-Pocket Maximum. However, a Member may receive Covered Services from a Non-Participating Provider for the following:

- Emergency 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 "If There Is No Participating Provider to Provide a Covered Service"
- Exceptions described under "Continuity of Care" section
- Exceptions described under "Transition of Care" section
- Exceptions described below under "Second Opinions from Non-Participating Providers"

To locate a Participating Provider, please refer to the provider directory at **MolinaMarketplace.com** or call Member Services.

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 Molina Customer Support.

Member Right to Obtain Healthcare Services Outside of Evidence of Coverage: 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 OOPM for any of services under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement.

Primary Care Provider (PCP): A Primary Care Provider (or PCP) takes care of routine and basic health care needs. PCPs provide Members with services such as physical exams, immunizations, or treatment for an illness or injury that is not needed on an urgent or emergency basis. Molina asks Members to select a PCP from the provider directory. If a PCP is not selected, one will be assigned by Molina. Members can request to change their PCP at any time at MyMolina.com or by contacting Member Services. 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 get the PCP 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.
- Member cost sharing is shown in the Schedule of Benefits.

Telemedicine Services: Telemedicine is a method of communication used by our Participating provider network to provide access to consult. It is covered at the same cost share as in person covered services.

Non-Participating Provider at a Participating Provider Facility: If a Member receives non-emergency care from a hospital-based Non-Participating Provider who is delivering services in a Participating Provider hospital, Molina shall pay as long as the care is:

- Medically Necessary
- A Covered Service

Non-Participating Providers delivering services in a Participating Provider hospital may include, but are not limited to, pathologists, radiologists, and anesthesiologists. The Member shall pay no more than the same Cost Sharing that the Member would pay for the same Covered Services received from a Participating Provider. Molina will reimburse the Non-Participating Provider for these services up to the Allowed Amount. The Member will be responsible for any applicable Cost Sharing described in the Schedule of Benefits.

No 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 the same Covered Services when rendered by Participating Providers. Prior Authorization is required before the initiation of the service. Molina will calculate our payment as the greatest of the following: Molina's usual and customary rate for such services, or an agreed upon rate for such services.

Under Texas Senate Bill 1264, an Out-of-Network Provider that rendered Emergency Care, an Out-of-Network facility based Provider that performed Services in an In Network Facility, and an Out-of-Network diagnostic imaging Provider or laboratory service Provider that performed Services in connection with In-Network care, may not be permitted to bill You for an amount greater than the applicable Copayment under the Member's Plan. The applicable Copayment for such Services will be based on the amount initially determined payable by Molina or a modified amount as determined under Molina's internal appeal process. However, the Member's Copayment will not be based on any additional amount determined to be owed to the Out-of-Network Provider under Insurance Code Chapter 1467 (relating to Out-of-Network Claim Dispute Resolution).

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. Member's 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

Some services and drugs must be approved by Molina before they will be covered for a Member. This process is called Prior Authorization. Most covered services are available a Member without Prior Authorization. If a service requires Prior Authorization, a Provider will request authorization from Molina on behalf of the Member. If authorization for a service is not provided by Molina, a Member may appeal the decision. For a complete list of covered services that do and do not require Prior Authorization, please visit MolinaHealthcare.com or call Customer Support. The following services always require authorization:

- Hospital/outpatient stay (non-emergency)
- Medical equipment and supplies
- Surgery
- Long term care (nursing home or rehab)

Molina will decide about Prior Authorization for a service within 3 calendar days after receiving the request and all medical information necessary to decide. Providers may request that Molina expedite the authorization process if the standard process would risk the Member's health are processed within 24 hours. This is 24 hours after receiving the request and all medical information necessary to decide. Molina will notify the Provider about the decision at the conclusion the approval process, within timeframes required by State and Federal law. If the request for service is not approved by Molina, the Member will be notified, including rights about how to appeal the denial. Prior authorization requirements for Covered Services are subject to change, and Members should contact the Customer Support Center of visit the Molina Marketplace website prior to receiving services.

Utilization Review: Licensed Molina staff processes Prior Authorization requests and conducts. Upon request in writing or by telephone, Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations by mail, fax, or call by Molina. Molina provides help and alternatives for care 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 precertification 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 24 hours or as soon as reasonably possible after the Member has been admitted. For outpatient and inpatient non-emergency medical services requiring Prior Authorization, a Member, their Provider, or the admitting facility must notify Molina at least 14 days before the outpatient care is provided, or the procedure is scheduled. For inpatient acute care, Molina will coordinate services within 24 hours and will continue to follow up every 24 hours.

Standing Approvals: If a Member has a health issue that requires specialized Covered Services over a continued period, a Member may request Standing Approval. If a Member receives Standing Approval, they will not need to get Prior Authorization every time obtain specialized Covered Services. A Member may receive a standing approval to a specialty care center with the expertise to treat a condition or disease is life threatening, worsening, or disabling. Molina will review an existing prior authorization received 60 days before the expiration of the existing preauthorization and issue a determination indicating whether the medical or health care service is preauthorized.

Referral: Your PCP may send You to another Provider for a specific Covered Service. This process is a Referral. A Referral is needed for some services before they will be covered.

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

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its agreement terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

DEFINITIONS

(a) A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

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

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance agreement that is designed to fully integrate with other policies through a variable.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense**.**
(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.
(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

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

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

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

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

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

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

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

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination

(1) among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

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

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

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

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

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

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

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

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

(I) the plan covering the custodial parent;
(II) the plan covering the spouse of the custodial parent;
(III) the plan covering the noncustodial parent; then
(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its

plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan amounts it would have credited to its amounts 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 must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Molina will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must Molina any facts it needs to apply those rules and determine benefits.

FACILITY OF PAYMENT: A payment made under another plan may include an amount that should have been paid under this plan. If it does, Molina 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.

RIGHT OF RECOVERY: 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.

Follow the steps described in the "Complaints" section. If you are still not satisfied, you may call the Texas Department of Insurance for instructions on filing a consumer complaint. Call **1-800-252-3439**, or visit Texas Department of Insurance website at www.tdi.texas.gov.

COST SHARING

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

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

COVERED SERVICES

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

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

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

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB) as defined by the Affordable Care Act (ACA) and its implementing 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 its implementing regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. However, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. on the last day of the month that they turn age 19. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage. Under the ACA and its implementing 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 Sharing amounts.
- Molina must ensure that the Cost Sharing that Members pay for all EHBs does not exceed an annual limit that is determined under the ACA.

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

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

Alternative to Hospitalization or Inpatient Care: To the extent mandated by State Law, home healthcare furnished by duly licensed home health, hospice and home care agencies covered by this Agreement may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home healthcare:

- Can be provided at equal or lesser cost;
- Is the most appropriate and cost-effective setting; and
- Is substituted with the consent of the Member and upon the recommendation of the Member's attending Physician or licensed health care Provider that such care will adequately meet the Member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the Member. Molina may require a written treatment plan that has been approved by the Member's attending Provider. Coverage of substituted home healthcare is limited to the maximum benefits available for Hospital or other inpatient care under this Agreement and is subject to any applicable Cost Sharing and limitations in this Agreement.

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

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

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

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 eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of 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:

- 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
- The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and Prior Authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. If a Member qualifies, Molina cannot deny their participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Member's routine patient costs associated with their participation in an approved clinical trial for which they qualify. Members will not be denied or excluded from any Covered Services under this Agreement based on their health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial. Molina does not have an obligation to cover certain items and services that are not routine patient costs, as determined by the Affordable Care Act, even when the Member incurs these costs while in an approved clinical trial. Costs excluded from coverage under this Plan include: The investigational item, device or service itself, items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and any service inconsistent with the established standard of care for the patient's diagnosis. All approvals and Prior Authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. Members will pay the Cost Sharing they would pay if the services were not related to a clinical trial. Members should contact Customer Support for further information.

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

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

- Preventive screening and testing (please refer to the Preventive Services section of this Agreement for full details)
- 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
- Prescription medications to treat cancer (please refer to the Prescription Drugs section of this Agreement for full details)

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 anesthesia
- 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

Molina does not provide pediatric dental services under this Agreement.

Dental Trauma: Molina covers services which are necessary for treatment or correction of a congenital defect; and Covered Oral Surgery. Covered Oral Surgery means maxillofacial surgical procedures limited to:

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

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

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

For information regarding Diabetes Supplies, please refer to the "Prescription Drugs" 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 Hospital or emergency room. When getting Emergency Services, Members should bring their Member ID card. Members who do not believe they need Emergency Services but who need medical help, should call their PCP, or call the 24-Hour Nurse Advice Line toll-free. Members should not go to an emergency room if the condition is not an Emergency.

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

Emergency Services by a Non-Participating Provider: Emergency Services for treatment of an Emergency Medical Condition are subject to Cost Sharing. This is true whether Emergency Services are provided by Participating Providers or Non-Participating Providers. Members should refer to the Cost Sharing for Emergency Services in the Summary of Benefits.

Services provided within an emergency room that do not meet the definition of Emergency Services are considered non-emergent and will be not covered.

Under Texas Senate Bill 1264, an Out-of-Network Provider that rendered Emergency Care, an Out-of-Network facility based Provider that performed Services in an InNetwork Facility, and an Out-of-Network diagnostic imaging Provider or laboratory service Provider that performed Services in connection with In-Network care, may not be permitted to bill You for an amount greater than the applicable Copayment under the Member's Plan. The applicable Copayment for such Services will be based on the amount initially determined payable by Molina or a modified amount as determined under Molina's internal appeal process. However, the Member's Copayment will not be based on any additional amount determined to be owed to the Out-of-Network Provider under Insurance Code Chapter 1467 (relating to Out-of-Network Claim Dispute Resolution).

Mandatory Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina reserves the right to require a transfer to a Participating Provider facility once the Member has stabilized sufficiently. If Molina requires a transfer, Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility. If the Member's coverage terminates during a Hospital stay, the services received after the termination date are not Covered Services.

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

Emergency Services Outside the United States: Covered Services include Emergency Services while traveling outside of the Service Area. This includes travel outside of the United States. For Emergency Services while traveling outside the United States, Members should use that country's or territory's emergency telephone number or go to the nearest emergency room.

Members who receive Emergency Services while traveling outside the United States will be required to pay the Non-Participating Provider's charges at the time they obtain those services. Members may submit a claim for reimbursement to Molina for charges that they paid for Covered Services received from the Non-Participating Provider.

Members are responsible for ensuring that claims and/or records of such services are appropriately translated. They are also responsible for ensuring that the monetary exchange rate is clearly identified when submitting claims for Emergency Services received outside the United States. Medical records of treatment and service may also be required for proper reimbursement from Molina. Claims for reimbursement for Covered Services should be submitted as follows:

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

Claims for reimbursement of Covered Services for Members traveling outside the United States must be verified by Molina before payment can be made. Molina will calculate the Allowed Amount that will be covered for Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws.

Because these services are performed by a Non-Participating Provider, Members will only be reimbursed for the Allowed Amount. The Allowed Amount may be less than the amount the Member was charged by the Non-Participating Provider. Members will not be entitled to reimbursement for charges for health care services or treatment that are not covered under this Agreement, specifically those identified in the Exclusions section of this Agreement.

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.
Emergency Medical Transportation provided by Participating Providers or Non-Participating Providers are covered at the cost share indicated on the Schedule of Benefits for the selected plan.

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, insert, maintain or remove a contraceptive device, such as intrauterine devices (IUD's).

Habilitation Services: Molina covers healthcare services and 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. Services include certain therapies for children with developmental delays in accordance with state law and an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

Home Healthcare: Molina covers home healthcare services on a part-time, intermittent basis to a Member confined to his or her home due to physical illness – when Prior Authorized and provided by a contracted home healthcare agency. Molina covers the following home healthcare services:

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

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

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

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

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

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

Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services (Inpatient and Outpatient): Molina covers laboratory, radiology (including X-ray and outpatient therapeutic radiology services) and scanning services at a Participating Provider. Covered scanning services can include CT Scans, PET Scans and MRI with Prior Authorization. Molina will help Members select an appropriate facility for these services. Limited coverage for Medically Necessary dental and orthodontic X-rays is outlined in the Dental and Orthodontic Services section of this Agreement. Services are subject to either outpatient or inpatient Cost Sharing

Mental Health Services (Inpatient and Outpatient): Molina covers inpatient and outpatient mental health services when provided by Participating Providers and facilities acting within the scope of their license. Except for involuntary admissions, all inpatient admissions, and certain outpatient services require Prior Authorization. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria. Benefits and coverage for mental health conditions are provided under the same terms and conditions applicable to the Molina's medical and surgical benefits and coverage; and Molina will not impose quantitative or nonquantitative treatment limitations on benefits for a mental health condition that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

A mental disorder is a mental health condition identified in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental disorders covered under this Agreement 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.

Inpatient and outpatient mental health services do not include therapy or counseling (e.g. career, marriage, divorce, parental or job). In addition, inpatient services do not include treatment or testing related to learning disabilities or mental retardation. Molina does not cover services for conditions that the DSM identifies as something other than a Mental Disorder.

Molina covers mental health services delivered in various settings, including:

- Services for children and adults in day treatment programs
- Services for persons with chronic Mental Disorders provided through a community support program
- Coordinated Emergency Services for Members who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Benefits for these services are to be provided for the time period the Member is experiencing the crisis until he/she is stabilized or referred to another provider for stabilization.

Molina covers the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

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

Non-Emergency Medical Transportation (NEMT): Non-routine, non-Emergency Medically Necessary ground transportation is covered when Molina determines such transportation is needed within Molina's Service Area to transfer a Member from one medical facility to another. This includes NEMT from one hospital to another hospital, from a hospital to a skilled nursing facility or hospice. NEMT is provided by wheelchair lift equipped vehicle, litter/stretcher van or non-Emergency ambulance (both advanced life support and basic life support). When NEMT is needed, Molina will arrange for the transportation to be provided by a Participating Provider transportation vendor. Please note, this is not a service for which Members can self-refer and any services not arranged by Molina will not be covered.

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

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

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

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

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

- Office visits, including:
  - Associated supplies
  - Pre and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician's office, an outpatient or an inpatient setting. Services are subject to either outpatient facility or inpatient facility Cost Sharing.
- Diagnostic procedures, including colonoscopies, including a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every 5 years, or a colonoscopy performed every 10 years; cardiovascular testing, including pulmonary function studies atherosclerosis and abnormal artery structure screening for diabetic enrollees and certain enrollees who have a documented medical risk of developing coronary heart disease; and neurology/neuromuscular procedures
- Radiation therapy
- 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. Covered dependents have direct access to obstetrical and gynecological care.
- Outpatient services by Other Practitioner

Specialist physician services
Sleep studies Prior Authorization is required, except for home 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 cover the following maternity care services:

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

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

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

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

Note: Pregnancy termination services that are provided in an inpatient or outpatient hospital setting require Prior Authorization. Condoms for male use are excluded under the Affordable Care Act and are not covered under this Agreement.

Preventive Services: Under 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://www.uspreventiveservicestaskforce.org/Page/Name/home.
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, those preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- In accordance with State Law, preventive services include:
    - CA 125 blood test for screening of ovarian cancer for women 18 years and older cancer screening. Molina also covers FDA-approved prescription contraceptive drugs and devices.
    - Annual Low-dose Mammograms, including breast tomosynthesis for women age 35 and over which must be performed at designated approved imaging facilities. Age limit does not apply to diagnostic screenings. Diagnostic screenings are to establish presence/absence of disease.
    - One low-dose mammography annually for the presence of occult breast cancer for persons the age of 35 and over. Age limit does not apply to diagnostic screenings. Diagnostic screenings are to establish presence/absence of disease.
    - Hearing screening (which includes hearing screening test from birth through the date the child is 30 days of age, refer to section " Hearing Services" for additional benefits where cost share may apply)
    - Administration of a newborn screening test, including the cost of a test kit in the amount required by Health and Safety Code §33.019

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. As new recommendations and guidelines for preventive services are published and recommended by the government sources 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 product year, also known as a agreement 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 implementing regulations and applicable State Law.

Prosthetic, Orthotic, Internal Implanted and External Devices: Molina covers the internal and

Internally implanted devices:

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

External devices:

- Artificial limbs needed due to loss resulting from disease, injury or congenital defect.
- Custom made prosthesis after mastectomy
- Podiatric devices to prevent or treat diabetes-related complications

Coverage is dependent on <u>all</u> the following requirements being met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes.
- The device is the standard device that adequately meets the Member's medical needs.
- The Member receives the device from the provider or vendor that Molina selects.

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

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
- For a child who is younger than 18 years of age, Molina covers reconstructive surgery for craniofacial abnormalities. Such coverage includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

The following reconstructive surgery services are not covered:

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

Rehabilitation Services: Molina covers services 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-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Services include certain therapies for children with developmental delays in accordance with state law and an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

Skilled Nursing Facility: Molina covers 25 days per calendar year at a skilled nursing facility (SNF) for a Member when the SNF is a Participating Provider and the services are Prior Authorized before they begin. Covered SNF services include:

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

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. Coverage includes room and board, Participating Provider physician services, dependency recovery services, education, and substance abuse/chemical dependency when Prior Authorized. Molina also provides coverage for substance use disorder treatment in a nonmedical transitional residential recovery setting when Prior Authorized. Molina covers the following outpatient care for treatment of substance use disorder:

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

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

Benefits and coverage for Substance Use Disorder conditions are provided under the same terms and conditions applicable to the Molina's medical and surgical benefits and coverage; and Molina will not impose quantitative or nonquantitative treatment limitations on benefits for a Substance Use Disorder that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

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 and oxygen services
- Antineoplastic surgical drugs
- Diagnostic testing
- Discharge planning
- General nursing care
- Inhalation therapy
- Inpatient drugs, medications, biologicals, anesthesia and oxygen services
- Meals and special diets when medically necessary
- Operating and related facilities (which includes room and board)
- Private Duty Nursing when medically necessary
- Radiation therapy
- Short-term rehabilitation therapy services in the acute hospital setting
- Use of intensive care unit and services
- Whole blood and blood, including the cost of blood, blood plasma, blood plasma expanders, and administration of whole blood and blood plasma
- X-ray services

Outpatient surgery services provided in any of the following locations:

- Diagnostic services
- Outpatient or ambulatory surgery center
- Hospital operating room
- Clinic
- Physician's office.

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

Temporomandibular Joint Syndrome ("TMJ") Services: Molina covers services to treat temporomandibular joint syndrome ("TMJ") 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:

- One surgical procedure per calendar year; and
- Three visits per calendar year for:
    - 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 may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications. Molina guidelines for donor services are available by calling Customer Support.

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

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

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

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

Low vision optical devices are covered, including low vision services, training, and instruction to maximize remaining usable vision. Follow-up care is covered when services are Medically Necessary and Prior Authorized. Laser corrective surgery is not covered.

PRESCIRPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Molina covers drugs ordered by Providers, approved by Molina, and filled through a pharmacy that is a Molina contracted pharmacy. Covered drugs include over-the-counter (OTC) and prescription drugs. Molina also covers drugs ordered or given in a participating facility when provided in connection with a Covered Service. Molina covers orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications. 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 Member and Provider if the request is either approved or denied based upon Medical Necessity review.

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

Molina will not deny reimbursement to a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license to practice pharmacy under Subtitle J, Title 3, Occupations Code, that: would be covered by the Agreement or other coverage Agreement if the service or procedure were provided by: a physician; an advanced practice nurse; or a physician assistant; and is performed by the pharmacist in strict compliance with laws and rules related to: the provision of the service or procedure; and the pharmacist's license.

Molina Formulary: Molina establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the "Formulary". The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with any coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on the Molina Marketplace website. A hardcopy is also available 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. Molina does not remove drugs from the Drug Formulary during the plan year. If drugs are discontinued Molina will notify You 30 days prior to the discontinuance of a concurrent prescription drug or intravenous infusion.

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 and 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 nonformulary drugs to be covered. Requests for coverage of nonformulary drugs will be considered for a medically accepted use when Formulary options cannot be used, and other coverage requirements are met. In general, drugs listed on the Formulary are drugs Providers prescribe for Members to get from a pharmacy and give to themselves. Most injectable drugs that require help from a Provider to use are covered under the medical benefit instead of the pharmacy benefit. Providers have instructions from Molina on how to get advanced approval for drugs they buy and treat Members with. Some injectable drugs can be approved to get from a pharmacy using the Plan pharmacy benefit.

Requesting an Exception: Molina has a process to allow Members to request clinically appropriate drugs that are not on the Formulary. Members may request coverage for drugs that have step therapy requirements or other restrictions under the Plan benefit that have not been met. Prescribers may contact Molina's Pharmacy Department to request a Formulary exception. If the request is approved, Molina will contact the Prescriber.

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

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

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

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

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

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

Cost Sharing: Molina puts drugs on different levels called tiers based on how well they improve health and their value compared to similar treatments. The Plan pharmacy benefit has six cost sharing levels. For Tiers 1 through 4, the lower the Tier, the lower the Member's share of the cost will be. The Schedule of Benefits shows Member Cost Sharing for a one-month supply based on these tiers. Molina will not require the Member to make payment for a prescription drug greater than the lesser of the applicable copayment allowable claim amount or the cash price. Here are more details about which drugs are on which tiers.

Drug Tier	Description
Tier 1	Preferred Generic drugs; Lowest cost sharing.
Tier 2	Non-Preferred Generic drugs and Preferred Brand-Name drugs; Higher cost sharing than Tier 1
Tier 3	Non-Preferred, Brand-Name and Generic drugs; Higher cost sharing than lower tier drugs used to treat the same conditions.
Tier 4	All Specialty Drugs; Brand-Name and Generic; Higher cost sharing than lower tier drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use the network specialty pharmacy.
Tier 5	Nationally recognized preventative service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 cost sharing.
DME	Durable Medical Equipment ("DME")- cost sharing applies; some non-drug products on the Formulary have cost sharing determined by the DME copayment.

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

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

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Over-the-Counter Drugs and Supplements: Molina covers over-the-counter drugs and supplements in accordance with State Law and Federal laws.

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

Eye Drops to treat chronic eye disease: Molina's pharmacy system will allow the Member to obtain refills for eye drops to treat chronic eye diseases and conditions at 21 day, 43 day and 63 day intervals.

Diabetic Supplies: Molina covers diabetic supplies on the Formulary such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, continuous glucose monitoring DME, blood glucose test strips, urine test strips, and select pen delivery systems for the administration of insulin. Molina also covers new or improved diabetic equipment and supplies, including improved insulin or another prescription drug approved by the United States Food and Drug Administration. Select pen delivery systems for the administration of insulin are also covered.

Prescription Drugs to Stop Smoking: Molina covers a three-month supply of drugs to help Members stop smoking, at 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 or Provider 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.

Step Therapy and Considerations for Drugs that require a Prior Authorization: Our Pharmacy Director and/or Our Medical Director will review general medical criteria and will work in conjunction with the Member's prescribing provider. The following parameters may be considered when reviewing the Member's request:

- diagnosis and relevant concurrent medical conditions,
- age, and sex,
- allergies,
- clinical rationale for selecting the drug,
- if the Member's condition being treated is consistent with FDA-approved indications and/or meets approved criteria for safe use,

- expected outcome of therapy and methods to be used to measure outcome,
- anticipated duration of therapy,
- previous experience with this drug, if any
- previous drug therapy, drug responses and adverse effects,
- concurrent drug therapy,
- compliance history,
- prescriber's familiarity with the drug,
- cost-effectiveness of the drug on overall healthcare costs, and
- whether or not the You have tried and failed an adequate supply of formulary drugs.

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

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, Members may be limited to coverage of a shorter supply per fill and subject to restrictions on long-acting opioid drugs and combined total daily doses. These requirements do not apply to Members in the following circumstances: Opioid analgesics are prescribed to a Member who is a hospice patient, the Member was diagnosed with a terminal condition, or the Member is actively being treated for cancer. Molina will conduct a utilization review for all opioid Prior Authorization requests.

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs and their administration. Requests for uses outside of a drug's FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on usage outside of FDA labeling. 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 are considered Tier 4 specialty drugs under the pharmacy benefit.
All anti-cancer drugs taken by mouth and paid for under the pharmacy benefit will be covered on the same basis and at no greater Cost Sharing than imposed under the medical benefit for anti-cancer drugs given by other bodily routes by a Provider.

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

Mail Order Availability of Formulary Drugs: Molina offers Members a mail order option for certain drugs in tiers 1, 2, 3 and 5. Eligible drugs are marked "MAIL" on the Formulary. Formulary drugs can be mailed to a Member within 10 days from order request and approval. Through this option, Members can get a 3-month supply of eligible drugs at reduced Cost Sharing. Cost Sharing for a 3-month supply through mail order is applied at a rate of two times the one-month supply Cost Share at the drug's Formulary tier. Tier 4 Specialty drugs are not eligible for mail order programs. Refer to the Molina Marketplace website or contact Member Services for more information.

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

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

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

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

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

HEARING SERVICES

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

We do cover the following:

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

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

COVERED SERVICES FURNISHED WHILE TRAVELING OUTSIDE THE SERVICE AREA (INCLUDING OUTSIDE OF THE UNITED STATES)

The Member's Covered Services include Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United States If You require Emergency Services while traveling outside the United States, please use that country's or territory's emergency telephone number or go to the nearest emergency room.

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

The Member's claims for reimbursement for Covered Services should be submitted as follows:

Molina Healthcare
PO Box 22719
Long Beach, CA 90801

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

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

Please see the Claims section of this EOC for additional details regarding how Molina Healthcare processes claims from Members.

EXCLUSIONS

Certain items 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.

Acupuncture Services: Acupuncture services or supplies are not covered.

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

Bariatric Surgery: Bariatric surgery 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 unless a Participating Provider determines that the services are Medically Necessary.

- Physical exams and other services that are:
  - Required for obtaining or maintaining employment or participation in employee programs,
- Required for insurance or licensing, or
- On court order or required for parole or probation.

This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary.

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

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

Dietician: A service of a Dietitian is not a covered service except for under following sections:

- Hospice Services
- Diabetes Services
- Autism Spectrum Disorder

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

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

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

Gene Therapy: Most gene therapy, including prescription drug gene therapy, is not covered. Molina covers limited 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 treatment of hair loss or hair growth are not covered.

Infertility Services All infertility services and supplies are not covered, except as covered in the Covered Services section, related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

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.

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

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

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

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

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

Oral Nutrition: Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

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

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

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

- A Hospital,
- A skilled nursing facility,

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

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

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

Services Provided Outside the Service Area: Any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. Only Emergency Services outside the Service Area are covered to treat an Emergency Medical Condition. 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 would not apply. Molina would cover any services that Molina would otherwise cover to treat that complication.

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

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

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

Vision Care Services: Molina does not cover the following:

- Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses
- Eye exercises, visual training, orthoptics, sensory integration therapy
- Radial keratotomy, laser surgeries, and other refractive keratoplasties
- Refractions (tests to determine if eyeglasses are needed, and if so, what prescription)

CLAIMS

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

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, Molina will pay the Provider of service within 30-45 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.

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

If the bill is for a prescription, the Member will need to complete a Reimbursement Form found in the Pharmacy section of the Molina website. Include a copy of the prescription label and pharmacy receipt when submitting this form to the address as instructed in the form. After Molina receives the request for reimbursement, Molina will respond to the Member within 30 calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member. If the claim is denied, Molina will send

the Member a letter explaining why the claim was denied. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

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

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

COMPLAINTS AND APPEALS

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER.

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

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

Complaint or Grievance: A Complaint and Grievance are synonymous and are any dissatisfaction that You have with Molina or any Participating Provider that is not related to the denial of healthcare services. For example, the Member may be dissatisfied with the hours of availability of their doctor. Issues relating to the denial of health care services are Appeals, and should be filed with Molina or the Texas Department of Insurance in the manner described in the Internal Appeals section below.

If You have a problem with any Molina Healthcare services:

- Call Molina Customer Service
- The Member may also send Molina the problem or complaint in writing by mail or filing online at molinamarketplace.com or you can mail to:

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

Molina recognizes the fact that Members may not always be satisfied with the care and services provided by Our contracted doctors, hospitals and other providers. A Member may file a grievance (also called a complaint) in person, in writing, or by telephone as described above. Molina also will provide oral language services that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language. A Member can request that any notice from Molina be provided in any applicable non-English language. With respect to any Texas county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language as determined by the Department of Health and Human Services (HHS).

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

Complaints concerning an emergency or a denial of continued hospitalization: Molina shall investigate and resolve a complaint concerning an emergency or denial of continued hospitalization not later than one (1) business day.

Appealing Resolution of Complaints: If a Member is not satisfied with the resolution the Member can appeal that resolution in writing. A Member may be requested to appear in person before a complaint appeal panel or address a written appeal to the complaint appeal panel. Molina will send an acknowledgment letter to the Member not later than the fifth business day after Molina receives the written request for appeal. Molina will complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

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

Complaints to TDI: A Complainant also has the right to file a complaint with TDI by contacting TDI at the following address, telephone numbers, or website:

Texas Department of Insurance
PO Box 149091
Austin, TX 78714-9091
1-800-252-3439
Fax: 512-490-1007
Online: www.tdi.texas.gov

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

Molina shall provide notice of an adverse determination as follows:

- With respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;
- With respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

The notice of an adverse determination will include:

- The principal reasons for the adverse determination;
- The clinical basis for the adverse determination;
- A description of or the source of the screening criteria used as guidelines in making the adverse determination;
- The professional specialty of the physician, doctor, or other health care provider that made the adverse determination;
- A description of the procedure for the URA's complaint system as required by §19.1705 of this title (relating to General Standards of Utilization Review);
- A description of the URA's appeal process, as required by §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination);
- A copy of the request for a review by an IRO form, available at www.tdi.texas.gov/forms;
- Notice of the independent review process with instructions that:
    - Request for a review by an IRO form must be completed by the enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the insurance carrier or URA that made the adverse determination to begin the independent review process; and
    - The release of medical information to the IRO, which is included as part of the independent review request for a review by an IRO form, must be signed by the enrollee or the enrollee's legal guardian; and
    - A description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an enrollee who:
        - has a life-threatening condition.
        - is requesting prescription drugs or intravenous infusions

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

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

You may request an Appeal of an Adverse determination. Appeal Procedures for Adverse determinations (Including Expedited Clinical Appeals)

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

Upon receipt of an expedited Prior Authorization or concurrent clinical appeal, Molina will notify the party filing the appeal as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. Molina will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by Molina.

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

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

How to Appeal an Adverse determination
An appeal of an Adverse determination may be filed by a Member or a person authorized to act on a Member's behalf, or health care provider. Designation of a representative must be in writing as it is necessary to protect against disclosure of information. To obtain an Authorized Representative Form, a Member or Member's representative may call Molina. Molina will review its decision in accordance with the following procedure:

- Within 180 days after a Member receives notice of an Adverse determination, call or write to Molina to request an appeal. A Member must identify the reasons for disagreement of the Adverse determination. Send the request to:

For review of claims for payment or reimbursement:

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

For appeal requests for services, including Prior Authorization:

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

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

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

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

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

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

Notice of Appeal Determination: Molina will notify the party filing the appeal, the Member, and, any health care provider who recommended the services involved in the appeal, by a written notice of the determination. The written notice will include:

- The clinical basis for the determination;
- A statement of the specific medical, dental, or contractual reasons for the resolution;
- A description of or the source of the screening criteria that were utilized in making the determination;
- Notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.1717 of this title (relating to Independent Review of Adverse Determinations);
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;

- The specialty of the physician or other health care provider making the determination;
- In certain situations, a statement in non—English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non—English language(s) and how to access Molina's language services; If the decision is a denial, the specialty of the physician or other health care provider making the denial; and
- An explanation of Molina's external review process to an Independent Review Organization (and how to initiate an external review of the determination).

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

Appeal to an Independent Review organization (IRO): Member may request an appeal to an Independent Review Organization ("IRO") of a denial of an appeal of an Adverse determination made by Molina.

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

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

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

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

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

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

OTHER

MISCELLANEOUS PROVISIONS

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

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

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

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

Organ or Tissue Donation: You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. You may choose to be an organ tissue donor by making that selection when the Member renews their Driver's License or pick up a form at the nearest Department of Public Safety office, or the Member can go online at www.donatelifeTexas.org to register.

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

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

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

Incontestability: All statements made by the Member on the enrollment application are considered representations and not warranties. The statements are considered truthful and made to the best of the Member's knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew an enrollee's coverage or reduce benefits unless:

- it is in a written enrollment application signed by the subscriber; and
- a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative

An individual contract or group certificate may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application.

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

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

BALANCE BILL NOTICE

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

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

NOTICE OF CERTAIN MANDATORY BENEFITS

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

Mastectomy or Lymph Node Dissection

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

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

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

Prohibitions

We may not:

- Deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- Provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- Reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
- Provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy: Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

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

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician. Percentage Cost Sharing and Copayment amounts will be the same as those applied to other similarly covered Inpatient Hospital Expense or Medical-Surgical Expense, as shown on the Schedule of Coverage.

Prohibitions

We may not:

- Offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
- Condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or
- Reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

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

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

Inpatient Stay Following Birth of a Child
For each person covered for maternity/childbirth benefits, We will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

- Give birth in a hospital or other health care facility; or
- Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

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

Prohibitions
We may not:

- Modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
- Offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
- Refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
- Reduce payments or reimbursements below the usual and customary rate; or
- Penalize a physician for recommending inpatient care for the mother or the newborn child.

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

the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY
Health benefit plan coverage for an acquired brain injury includes the following services:

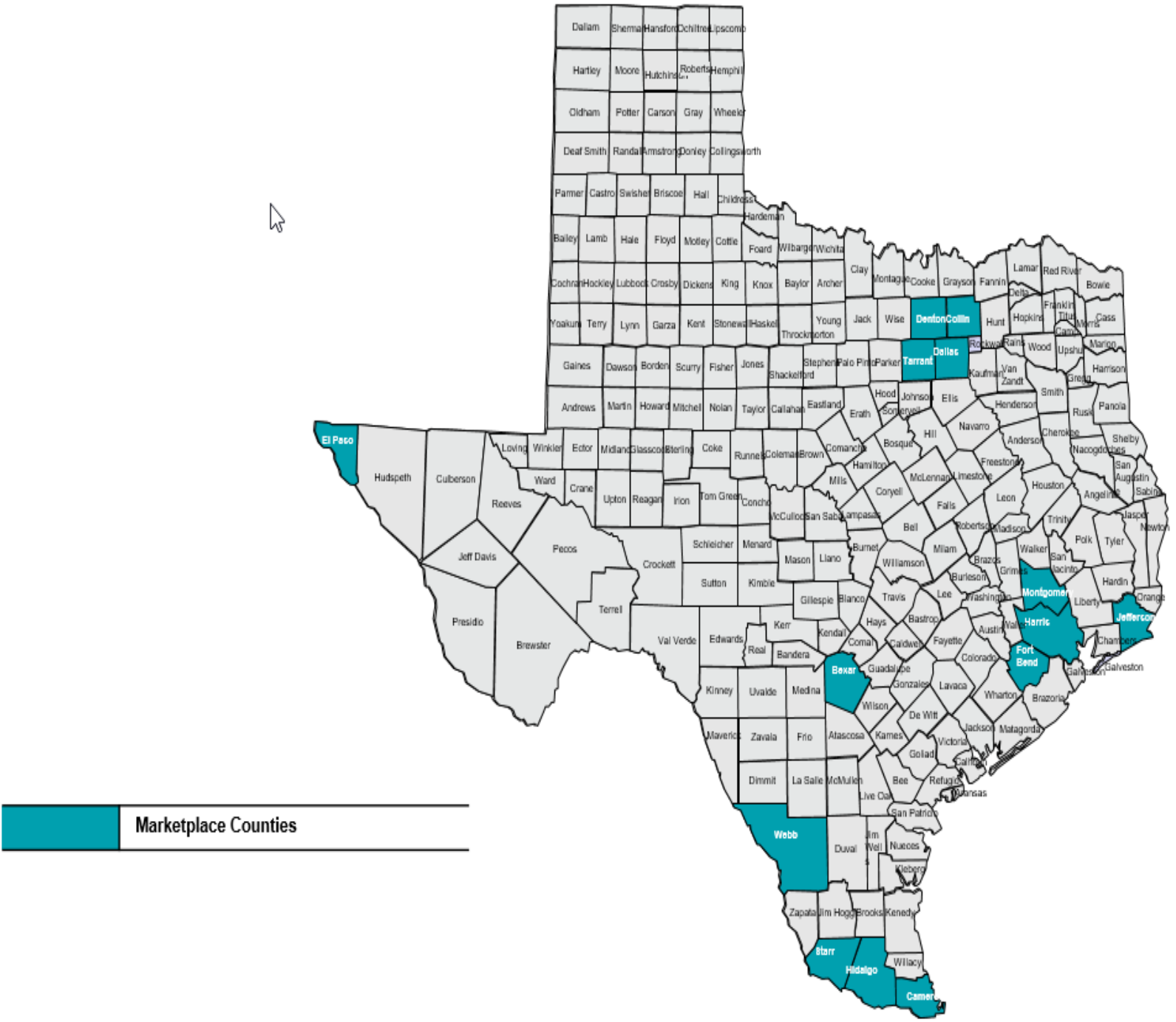
- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community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

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

Wellness Program: This Agreement includes access to a health activities program. The goal of the program is to encourage Members to complete health activities that support their overall health. The program is voluntary and available at no cost. The health activities Molina encourages Members to complete are described below. For more information, please contact Customer Support.

Annual Health Activity: Molina encourages Members to complete an Annual Wellness Exam (a comprehensive physical exam), at no cost, through their PCP or an in-home health assessment exam facilitated through Molina

MOLINA HEALTHARE OF TEXAS, INC. SERVICE AREA MAP



MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

LANGUAGE ACCESS

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

Arabic	إذا كانت لديك أنت أو أي شخص آخر تساعده أسئلة حول Molina Marketplace، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث إلى مترجم فوري، اتصل على
Chinese	如果您，或是您正在協助的對象，有關於Molina Marketplace方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1 (888) 560-2025。
French	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Molina Marketplace, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1 (888) 560-2025.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Molina Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1 (888) 560- 2025 an.
Gujarati	જો તમને અથવા તમે જેને મદદ કરી રહ્યાં હોવ એવી કોઈ વ્યક્તિને Molina Marketplace વિશે પ્રશ્નો હોય, તો કોઈ ખર્ચે વગર તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1 (888) 560 2025 પર કૉલ કરો.
Hindi	यदि आपके या आपके द्वारा सहायता किए जा रहे किसी व्यक्ति के पास Molina Marketplace के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ़्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी भी दूरभाषिए से बात करने के लिए, 1 (888) 560-2025 पर कॉल करें।
Japanese	ご本人様、またはお客様の身の回りの方でも、Molina Marketplace について ご質問がございましたら、ご希望の言語でサポートを受けたり、情報 を入手したりすることができます。料金はかかりません。通訳とお話さ れる場合、1 (888) 560-2025までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Molina Marketplace 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1 (888) 560-2025로 전화하십시오.
Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Molina Marketplace, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ຕ້ອງເສຍຄ່າບໍລິການ. ຖ້າທ່ານຕ້ອງການເວົ້າກັບລ່າມແປພາສາ, ກະລຸນາໂທຫາ 1 (888) 560-2025.
Persian-Farsi	اگر شما یا کسی که به آن کمک می‌کنید سؤالی دربارهٔ Molina Marketplace دارید، می‌توانید کمک و اطلاعات را به زبان خودتان و به طور رایگان دریافت کنید. برای صحبت با مترجم شفاهی با 1 (888) 560-2025 تماس بگیرید.

Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Molina Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1(888) 560-2025.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Molina Markeplace tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1 (888) 560-2025.
Tagalog	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Molina Marketplace, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1 (888) 560-2025.
Urdu	اگر آپ، یا کوئی اور جن کی آپ مدد کر رہے ہیں، ان کے پاس Molina Marketplace کے بارے میں سوالات ہوں، تو آپ کو بغیر کسی قیمت کے اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق حاصل ہے۔ کسی ترجمان سے بات کرنے کے لیے، 560-2025 (888) 1 پر کال کریں۔
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Molina Marketplace, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1 (888) 560-2025.