MOLINA® HEALTHCARE

Marketplace Benefit Interpretation

Marketplace National Regional Benefit Interpretation Document

Benefit Name	CONTINUITY OF CARE/TRANSITION OF CARE
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	This policy addresses continuity of care conditions and continuing care with a terminated provider for active members. Also, this policy addresses transition of care for new members. Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern. **Continuity of Care:** The American Academy of Family Physicians defines continuity of care as "the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective medical care." This has an impact on active members. § 156.235 Under Provider Transitions, A QHP issuer in a Federally-facilitated Exchange must 1. Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal; 2. In cases where a provider is terminated without cause, allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. (i) For the purposes of paragraph (d)(2) of this section, active course of treatment means:

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(A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

(B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(C) The second or third trimester of pregnancy, through the postpartum period; or

(D) 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.

(ii) Any QHP issuer decision made for a request for continuity of care under paragraph (d)(2) of this section must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

Transition of Care: A set of actions designed to ensure coordination and continuity. They should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient’s treatment goals, preferences, and health or clinical status. They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition. This has an impact on new members.

A. FEDERAL/STATE MANDATED REGULATIONS

Note: The most current federal/state mandated regulations for each state can be found in the links below.

CALIFORNIA:

California Health & Safety Code § 1399.63-Required Coverage: (only applies to an employer that is no longer in business)
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1399.63.

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a) Any carrier providing replacement coverage with respect to hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuance, including all former employees entitled to continuation coverage under Section 1373.621, who are within the definitions of eligibility under the succeeding carrier's contract and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active full-time employment or hospital confinement or pregnancy. However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (b) of Section 1399.62, or pursuant to subdivision (d) of Section 10128.2 of the Insurance Code, the succeeding carrier is not required to provide benefits for services or expenses directly related to any conditions which caused the total disability.

b) Except as otherwise provided in subdivision (a), until an employee or dependent entitled to coverage under a succeeding carrier's contract pursuant to subdivision (a) of this section qualifies for full benefits by meeting all effective date requirements of the succeeding carrier's contract, the level of benefits shall not be lower than the benefits provided under the prior carrier's contract or policy reduced by the amount of benefits paid by the prior carrier. Such employee or dependent shall continue to be covered by the succeeding carrier until the earlier of the following dates:
1) The date coverage would terminate for an employee or dependent in accordance with the provisions of the succeeding carrier's contract, or

2) In the case of an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (d) of Section 10128.2 of the Insurance Code or subdivision (b) of Section 1399.62, the date the period of extension of benefits terminates or, if the prior carrier's contract or policy is not subject to this article, the date to which benefits would have been extended had the prior carrier's contract or policy been subject to this article.

c) Except as otherwise provided in this section, and except to the extent that benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding

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carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those employees, former employees entitled to continuation coverage under Section 1373.621, and dependents validly covered under the prior carrier's contract or policy on the date of discontinuance.

d) In a situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination by the succeeding carrier.

e) For purposes of subdivision (a), a succeeding carrier's coverage shall not exclude any dependent child who was covered by the previous carrier solely because the plan member does not provide the primary support for that dependent child.

f) Except to the extent that benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in the succeeding carrier's contract, where an employee changes carriers due to a change in employment or other circumstances, that would operate to reduce or exclude benefits for the following congenital craniofacial anomalies: cleft lip and palate (as defined in ICD-9-CM Diagnosis Code 749, International Classification of Diseases, 9th Revision, Clinical Modification, Volume 1, Second Edition, September, 1980), acrocephalosyndactyly (as defined in ICD-9-CM Diagnosis Code 755.55, cranio only), and other congenital musculoskeletal anomalies (as defined in ICD-9-CM Diagnosis Code 756.0), on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract, shall be applied to those employees, former employees entitled to continuation coverage under Section 1373.621, and dependents validly covered under the prior carrier's contract or policy on the date the prior contract or policy terminated when payment or services had been commenced by the previous carrier. That succeeding coverage shall otherwise be subject to all other provisions of the contract between the insured and the succeeding carrier. Nothing in this subdivision shall be construed to limit or otherwise affect any obligation of a succeeding carrier to provide benefits for a condition not specified in this subdivision, where expressly or impliedly required by other provisions of this chapter; this subdivision is not intended to affect the construction of the language of any other provision of this chapter.

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California Health and Safety Code § 1373.96 Continuity of Care
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1373.96&lawCode=HSC
(a) A health care service plan shall, at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.
(b) (1) The completion of covered services shall be provided by a terminated provider to an enrollee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).
(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).
(c) The health care service plan shall provide for the completion of covered services for the following conditions:

An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract

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termination date or 12 months from the effective date of coverage for a new enrollee.
(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
(d) (1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.
(2) Unless otherwise agreed upon by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the
terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.
(e) (1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.
(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates

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and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, copayments, deductibles, or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section does not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(i) This section does not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. Except as provided in subdivision (l), this section shall not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j) Except as provided in subdivision (l), this section does not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(k) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. This section does not l preclude a plan from providing continuity of care beyond the requirements of this section.

(l) (1) A health care service plan shall, at the request of a newly covered enrollee under an individual health care service plan contract, arrange for the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (c) if the newly covered enrollee meets both of the following:

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(A) The newly covered enrollee's prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 or subdivision (d) or (e) of Section 10273.6 of the Insurance Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.
(B) At the time his or her coverage became effective, the newly covered enrollee was receiving services from that provider for one of the conditions described in subdivision (c).
(2) The completion of covered services required to be provided under this subdivision apply to services rendered to the newly covered enrollee on and after the effective date of his or her new coverage.
(3) (3) A violation of this subdivision does not constitute a crime under Section 1390.
(m) Notice as to the process by which an enrollee may request completion of covered services pursuant to this section shall be provided in every disclosure form as required under Section 1363 and in any evidence of coverage issued after January 1, 2018. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (l).
(n) The following definitions apply for the purposes of this section:
(1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
(2) "Nonparticipating provider" means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.
(3) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.
(4) "Provider group" means a medical group, independent practice association, or any other similar organization.
(Amended by Stats. 2018, Ch. 92, Sec. 133. (SB 1289) Effective January 1, 2019.)

Section 2240.1: Adequacy and Accessibility of Provider Services

FLORIDA:

641.512: Accreditation and external quality assurance assessment

ILLINOIS:

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45 CFR 156.230(d)(2): Network adequacy standards
215 ILCS 134/25: Transition of Services
50 IAC 4520.60: Transition of Services
215 ILCS 124/20(a) & (b): Transition of services

NEW MEXICO:

13.10.23.13 NMAC

SOUTH CAROLINA:

SECTION 38-71-243: Continuation of care; definitions; applicability; requirements

TEXAS:

Texas Insurance Code §1252.202 - Effective Date of Coverage under Replacement Plan

a. An individual who was covered by a previous carrier's health benefit plan on the date on which that plan was discontinued shall be provided coverage under the succeeding carrier's health benefit plan as of the replacement plan's effective date if the individual:
1) Is eligible for coverage because the individual is a member of a class eligible for coverage under the replacement plan and satisfies the replacement plan's actively at work and nonconfinement requirements; and

2) Elects to be covered under the replacement plan

b. An individual who would be covered by the succeeding carrier under Subsection (a) but who does not satisfy the replacement plan's actively at work and nonconfinement requirements shall be covered under the replacement plan when the individual satisfies those requirements.

Texas Insurance Code §1252.207- Liability of Previous Carrier
A carrier of a health benefit plan that is being discontinued is liable only for any accrued liabilities regarding the plan and for any extension of benefits provided under the plan, regardless of whether the group policyholder or any other entity responsible for making payments or for submitting subscription charges to the carrier:
1. Replaces the coverage provided under the discontinued plan with health benefit plan coverage provided by another carrier;
2. Self-insures a health benefit plan; or
3. Does not provide health benefit plan coverage

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TIC §843.309 : CONTRACTS WITH PHYSICIANS OR PROVIDERS: NOTICE TO CERTAIN ENROLLEES OF TERMINATION OF PHYSICIAN OR PROVIDER PARTICIPATION IN PLAN
§843.362: Continuity of Care (using global language first)

TIC §843.361- ENROLLEES HELD HARMLESS
§843.362(d)(2)- CONTINUITY OF CARE
42 USC §300gg113

WASHINGTON:

RCW 48.46.440**-** Continuation Option to be Offered
Every health maintenance organization that issues agreements providing group coverage for hospital or medical care shall offer the agreement holder an option to include an agreement provision granting a person who becomes ineligible for coverage under the group agreement, the right to continue the group benefits for a period of time and at a rate agreed upon. The agreement provision shall provide that when such coverage terminates the covered person may convert to an agreement as provided in RCW 48.46.450.

RCW 48.46.450- Conversion Agreement to be Offered – Exceptions, Conditions
(1) Except as otherwise provided by this section, any group health maintenance agreement that provides benefits for hospital or medical care must contain a provision granting a person covered by the group agreement the right to obtain a conversion agreement from the health maintenance organization upon termination of the person's eligibility for coverage under the group agreement.
(2) A health maintenance organization need not offer a conversion agreement to:
(a) A person whose coverage under the group agreement ended when the person's employment or membership was terminated for misconduct: PROVIDED, that when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct;
(b) A person who is eligible for federal Medicare coverage; or
(c) A person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

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(3) To obtain the conversion agreement, a person must submit a written application and the first premium payment for the conversion agreement not later than thirty-one days after the date the person's eligibility for group coverage terminates or thirty-one days after the date the person received notice of termination of coverage, whichever is later. The conversion agreement shall become effective without lapse of coverage, immediately following termination of coverage under the group agreement.

(4) If a health maintenance organization or group agreement holder does not renew, cancels, or otherwise terminates the group agreement, the health maintenance organization must offer a conversion agreement to any person who was covered under the terminated agreement unless the person is eligible to obtain group benefits for hospital or medical care within thirty-one days after such nonrenewal, cancellation, or termination of the group agreement or thirty-one days after the date the person received notice of termination of coverage, whichever is later.

(5) The health maintenance organization shall determine the premium for the conversion agreement in accordance with the organization's table of premium rates applicable to the age and class of risk of each person to be covered under the agreement and the type and amount of benefits provided.

B. STATE MARKET PLAN ENHANCEMENTS

CONTINUITY OF CARE

The NAIC Model Laws, Regulations, Guidelines and Other Resources (Fall 2019) tracks what states have adopted the Federal Language fully and what states may have deviated from the Federal Language. The Date and Time varies for each state based on Federal and State Regulations. Please refer to the below covered section for each state.

CALIFORNIA:

Members may be able to stay with the doctor or hospital **for up to 12 months**.

FLORIDA:

Members may have a right to continue receiving Covered Services from that provider until the **Active Course of Treatment is complete or for 6 months**.

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

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Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

CONTINUITY OF CARE/TRANSITION OF CARE

CALIFORNIA:

Continuity of Care: If a Member is assigned to a PCP or hospital that is ending a contract with Molina, then Molina will provide the Member 60 calendar days advance written notice of such a contract ending between Molina and PCP or acute care hospital.

If a Member is undergoing treatment for one of the conditions listed below and the doctor or hospital providing treatment is no longer a Participating Provider with Molina, the Member may ask Molina's permission to stay with the doctor or hospital for continuity of care.

The following conditions may be eligible for continuity of care:

- A Member has a serious chronic condition. "Serious Chronic Condition" means a medical condition due to a disease, illness, or other medical problem or disorder that is serious in nature, and that does either of the following:
  - Persists without full cure or worsens over an extended period.
  - Requires ongoing treatment to maintain remission or prevent getting worse.

  For a Serious Chronic Condition, **a Member may be able to stay with the doctor or hospital for up to 12 months.**
- A Member is pregnant. The Member may stay with the doctor or hospital for the length of the pregnancy. The length of the pregnancy includes the three trimesters of pregnancy and the immediate postpartum period.
- A Member presents written documentation of being diagnosed with a maternal mental health condition from the treating health care provider. "Maternal Mental Health Condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. If a Member has a Maternal Mental Health Condition, the Member may be able to stay with the doctor or hospital for up to 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
- A Member has an acute condition. "Acute Condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. The Member may stay with the doctor or hospital for the length of the acute condition.

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- A Member's child is a newborn or child up to age 36 months. The Member's child may stay with the doctor or hospital for up to 12 months.
- A Member has a terminal illness. The Member may stay with the doctor or hospital for the length of the illness.
- A Member has received Prior Authorization for a surgery or other procedure to be performed within 180 calendar days of the date the doctor or hospital will no longer be with Molina.

Eligibility for continuity of care is not based strictly upon the name of the Member's condition.

The doctor or hospital might not agree to continue providing services or might not agree to comply with Molina's contractual terms and conditions that are imposed on Participating Providers. If that happens, Molina will assign the Member to a new doctor or send the Member to a new hospital for care.

To submit a request to stay with the same doctor or hospital for continuity of care, a Member should call Member Services.

If a Member is newly enrolled and the Member's prior coverage was terminated because the Member's prior plan withdrew that product from any portion of the market or the plan ceased to sell products in any portion of the market, the right to temporary continuity of care, as described above, does apply.

Transition of Care: Molina provides Medically Necessary Covered Services on or after a 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 the Member's coverage is effective with Molina.

After a Member's effective date with Molina, at the Member's request, Molina may allow the Member to continue receiving Medically Necessary Covered Services for an ongoing course of treatment through completion with a Non-Participating Provider. Molina may coordinate the provision of Covered Services with any Non-Participating Provider (physician or hospital) on the Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

For Inpatient Hospital Services: With the Member's assistance, Molina may reach out to any prior insurer (if applicable) to determine the prior insurer's responsibility for payment of inpatient hospital services through discharge of any inpatient admission. If there is no transition of care provision through the prior insurer or the 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 the Member's coverage with Molina, not prior.

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FLORIDA:

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 6 months, whichever is shorter, at in-network Cost Sharing. Prior Authorization is required. An Active Course of Treatment is:

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

Continuity of care will end when the earliest of the following conditions has 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 completion of the 6th month of continuity of care;
- Upon completion of the 6th month of continuity of care;
- The Member has met or exceeded the benefit limits under their plan;
- Care is not Medically Necessary;
- Care is excluded from a Member's coverage; or
- The Member becomes ineligible for coverage.

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition.

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,

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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.

IDAHO:

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

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

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

- Upon successful transition of care to a Participating Provider if the Member

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

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

In the event the Molina cancels or refuses to renew this Agreement, this Agreement will provide for an extension of benefits as to pregnancy commencing while the Agreement is in force and for which benefits would have been payable had the Agreement remained in force.

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

1. Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.
2. Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina) may be responsible for coverage until a Member's coverage is effective with Molina.
3. After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider on a Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.
4. For Inpatient Services: With the member's assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of inpatient hospital services through

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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.

ILLINOIS:
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 second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care Provider attests that discontinuing care by that physician or health care Provider would worsen the condition or interfere with anticipated outcomes.

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

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

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Molina's Allowed Amount or an agreed upon rate for such services. If Molina and the Provider are unable to settle on an agreed upon rate, the Member may be responsible to the

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Provider for any billed amounts that exceed Molina's Allowed Amount. That would be in addition to any in-network Cost Sharing amounts that Members owe under this Agreement. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Member's Deductible or OOPM.

Transition of Care: Molina may allow a new Member to continue receiving Covered Services for an ongoing active 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 the 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.

KENTUCKY:

Continuity of Care: Members receiving an Active Course of Treatment (as defined below) for Covered Services from a Participating Provider whose participation with Passport 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 defined as:

- 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

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person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy;
- An ongoing course of treatment for "Special Circumstances," which includes a circumstance in which a covered person has a disability, a congenital condition, a life-threatening illness, or is past the twenty-fourth week of pregnancy where disruption of the covered person's continuity of care could cause medical harm;
- The second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care Provider attests that discontinuing care by that physician or health care Provider would worsen the condition or interfere with anticipated outcomes.

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

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

Transition of Care: Passport may allow a new Member to continue receiving Covered Services for an ongoing course of treatment with a Non-Participating Provider until Passport arranges a transition of care to a Participating Provider, under the following conditions:
1. Passport will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically

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Necessary, through the Prior Authorization review process. Members may contact Passport to initiate Prior Authorization review.

2. Passport will only provide Covered Services on or after Member's effective date of coverage with Passport, not prior. A prior insurer (if there was no break in coverage before enrolling with Passport) may be responsible for coverage until a Member's coverage is effective with Passport.
3. After a Member's effective date with Passport, Passport 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 Passport Participating Provider.
4. For Inpatient Services: With the member's assistance, Passport 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, Passport will assume responsibility for Covered Services upon the effective date of coverage with Passport, but not prior to the effective date of coverage.

MICHIGAN:

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 second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care Provider attests that discontinuing care by that physician or health care Provider would worsen the condition or interfere with anticipated outcomes.

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

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

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

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

1. Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through the Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.
2. Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina) may be responsible for coverage until a Member's coverage is effective with Molina.
3. After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider on a Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.
4. For Inpatient Services: With the member's assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of inpatient Hospital

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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.

MISSISSIPPI:
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 second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

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

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

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Molina's Allowed Amount or an agreed upon rate for such services. If Molina and the provider are unable to settle on an agreed upon rate, the Member may be responsible to the

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provider for any billed amounts that exceed Molina's Allowed Amount. That would be in addition to any in-network Cost Sharing amounts that Members owe under this Agreement. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Member's Deductible or OOPM.

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

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

NEW MEXICO:

Continuity of Care: Members receiving an Active Course of Treatment for Covered Services from a Participating Provider whose participation with Molina is ending. When Molina terminates or suspends any contract with a Participating Provider, Molina shall notify, in writing, affected covered Members who are current patients of or, where applicable, assigned to the provider, within 30 days. The notice to covered Members shall advise them of their right to continue receiving care from the provider as set forth in 13.10.23.13 NMAC. Current patients are covered Members who have a claim with Molina related to the

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provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

- Molina shall assist such affected covered Members in locating and transferring to another similarly qualified provider.
- A covered Member may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered Member, if the covered Member has not received comparable notice during this time from the provider.

The Member 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 second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

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

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

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Molina's Allowed

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

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

- 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. Previous 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.

OHIO:

Continuity of Care: Members receiving an Active Course of Treatment for Covered Services from a Participating Provider may have a right to continue receiving Covered Services from that Provider if, during an Active Course of Treatment, either of the following occurs:

- The expiration or nonrenewal of the Participating Provider's agreement with Molina, except for any termination of the agreement for failure to meet applicable quality standards or fraud; or
- Benefits provided under this Contract with respect to such Provider are terminated because of a change in the terms of the participation of the Provider.

In either case, Members will be timely notified of their right to elect continued care from such Provider under the same terms and conditions that would have applied if the Provider was still a Participating Provider. If the Member elects to continue the care, these terms and conditions will apply for 90 days from

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Molina's notice or until the Active Course of Treatment ends, whichever is shorter.

An Active Course of Treatment is when the Member:

- Is undergoing an ongoing course of treatment for a Serious and Complex Condition, which is an acute illness or condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or a chronic illness or condition that life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- Is undergoing a course of institutional or inpatient care;
- Is scheduled to undergo non-elective surgery, including post-operative care;
- Is pregnant and undergoing a course of treatment for the pregnancy; or
- Is or was determined to be terminally ill, meaning that the Member's life expectancy is 6 months or less, and is receiving treatment for the terminal illness.

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

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

1) Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through the Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.
2) Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina) may be responsible for coverage until a Member's coverage is effective with Molina.
3) After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider

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on a Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

4) For Inpatient Services: With the member's assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of inpatient Hospital services through discharge of any Inpatient admission. If there is no transition of care provision through the Member's prior insurer or if a Member did not have coverage through an insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of coverage with Molina, not prior.

SOUTH CAROLINA:

Continuation of Care (Continuity of Care): Members receiving Covered Services for a Serious Medical Condition and provided by a Participating Provider whose participation with Molina is ending without cause may have a right to continue receiving Covered Services from that Provider for 90 days or until the termination of the benefit period, whichever is greater, at the same Cost Sharing that would apply if services were provided by a Participating Provider.

For purposes of this "Continuation of Care" section, "Serious Medical Condition" means a health condition or illness, that requires medical attention, and where failure to provide the current course of treatment through the current Provider would place the Member's health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy.

Continuation of care will end after 90 days or after termination of the benefit period, whichever is greater. Otherwise, continuation of care may end when the earliest of the following conditions has been met:

- upon successful transition of care to a Participating Provider
- upon completion of the course of treatment
- if the Member has met or exceeded the benefit limits under the Plan
- if care is not Medically Necessary
- if care is excluded from coverage
- if the Member becomes ineligible for coverage

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition. Unless otherwise required by law, Molina will reimburse the Provider up to the previously contracted amount for such service.

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

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

TEXAS:

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 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;

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- Pregnancy through the postpartum period and a follow-up checkup within the six-week period after delivery;
- A covered person undergoing a course of institutional or inpatient care from the provider or facility; or
- A covered person scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

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

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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.

UTAH:

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

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

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

- Upon successful transition of care to a Participating Provider, if the Member chooses to transition their care.
- Upon completion of the course of treatment prior to the 90th day of continuity of care

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- Upon completion of the 90thday of continuity of care
- The Member has met or exceeded the benefit limits under their plan
- Care is not Medically Necessary
- Care is excluded from a Member's coverage
- The Member becomes ineligible for coverage

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

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

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

WASHINGTON:

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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 second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

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

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

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

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

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

WISCONSIN:

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 second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing

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care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

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

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

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

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

1. Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through the Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.
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3. After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider on a Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.
4. For Inpatient Services: With the member's assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior

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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.

D. NOT COVERED

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

E. DEFINITIONS

See Glossary

F. POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
4/15/2021	• Added KY 2022 Drafted Language
5/14/2021	• Added IL 2022 EOC Language
6/28/2021	• Added ID 2022 EOC Language

Procedure Codes (Internal Use Only)

None
Prior Auth required, and Configuration will process the claim accordingly.

Prior Authorization

For the MHI PA Matrix, if a code is NOT listed, it could EITHER be:

a. Covered and No PA Required
b. Not Covered

You cannot use the MHI PA Matrix to make coverage determinations.

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	PA Lookup Tool
Approval	

Departments	Product	CIM	Clinical Management
Date (Initial)	4/27/2021	5/17/2021	4/21/2021
Revised (for 1/1/2022)	10/26/2021	3/3/2022	10/26/2021
Revised (for 1/1/2023)	10/27/2022		10/27/2022

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