



Molina Healthcare of Florida, Inc. Marketplace

2024 | Agreement and Individual Evidence of Coverage

Molina Healthcare of Florida
8300 NW 33 St., Suite 400
Doral, FL 33122

Service Area: Counties of Broward, Clay, Duval, Hillsborough, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, and Seminole.

A handwritten signature in blue ink, appearing to read "Michael J. Jones", written over a horizontal line.

Officer's Signature

Michael J. Jones, Plan President

Service	Need	Where to Go
Emergency Services	<ul style="list-style-type: none"> Treatment of an Emergency Medical Condition 	Call 911 , or go to any hospital emergency room, even if it is a Non-Participating Provider or outside of the Service Area.
Getting Care	<ul style="list-style-type: none"> Urgent Care <ul style="list-style-type: none"> Minor Illnesses Minor Injuries Virtual Care 24-hour advice on medical and mental health questions 	<p>Urgent Care Centers Find a Provider or Urgent Care center MolinaMarketplace.com/FLFindCare</p> <p>Virtual Care www.teladoc.com/molinamarketplace 1-800-TELADOC</p> <p>24-Hour Nurse Advice Line 1 (888) 275-8750 (English) 1 (866) 648-3537 (Spanish) TTY: 711</p>
Online Access	<ul style="list-style-type: none"> Find or change a doctor View benefits and Member Handbook View or print ID card Track claims 	<p>Go to MyMolina.com</p> <p>Download the Molina Mobile App</p> <p>Visit the Provider Directory MolinaMarketplace.com/FLFindCare</p>
Plan Details	<ul style="list-style-type: none"> Answers about your plan, programs, services, or prescription drugs ID card support Access to care Prenatal care Well-infant visits Payment questions 	<p>Molina Customer Support Center 1 (888) 560-5716 Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern TTY: 711</p> <p>Go to MyMolina.com</p>
Eligibility & Enrollment	<ul style="list-style-type: none"> Eligibility questions Add a Dependent Report changes of address or income 	<p>Go to HealthCare.gov</p> <p>1 (800) 318-2596</p>

Interpreter Services: Molina offers interpreter services for any Member who may need language assistance to understand and obtain health coverage under this Agreement. Molina provides these services 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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Policy Issuance: This Molina Healthcare of Florida, Inc. Agreement and Individual Evidence of Coverage (also called the “Agreement”) is issued by Molina Healthcare of Florida, Inc., (“Molina,”), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Molina agrees to provide the Covered Services as outlined in this Agreement.

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

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

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

Thank You for Choosing Molina

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

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

How you can get services through Molina

- Getting an interpreter
- Choosing a Primary Care Provider (PCP)
- Making an appointment

The terms and conditions of coverage under this Agreement

Benefits and coverage as a Molina Member

- Checking on Prior Authorization status

How to contact Molina

Please read this Agreement carefully. Inside is information about a wide range of health needs and services provided. For questions or concerns, please reach out to Customer Support at MolinaMarketplace.com or 1 (888) 560-5716.

We look forward to serving you,

Molina Marketplace

DEFINITIONS

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

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.

Covered Services obtained from a Participating Provider will be reimbursed at the contracted rate with the Participating Provider for such Covered Services.

Emergency 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 lesser of:

- 1) The provider’s billed charges,
- 2) The usual and customary provider charges for similar charges in the community where the services were provided, or
- 3) The charged mutually agreed upon by Molina and the Non-Participating Provider within 60 days of the submittal of the claim.

Air Ambulance Services (both emergency and non-emergency) furnished by a Non Participating Provider will be paid at a reasonable amount, pursuant to state law.

All other Covered Services received from a Non-Participating Provider in accordance with this Agreement (including Post-Stabilization Services): 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.

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

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

amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

- 1) the individual OOPM will be met, with respect to the Member, when that person meets the individual OOPM amount; or
- 2) the family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount.

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

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

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

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

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

Cost Sharing: The share of costs that a Member will pay out of their own pocket for Covered Services. This term generally includes Deductibles, Coinsurance, and Copayments, but it doesn't include Premiums, Balance Bill amounts for non-network providers, or the cost of non-covered service.

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

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

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

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

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

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

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

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

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

Emergency Services: Medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital or independent freestanding emergency department. This can also include Emergency Transportation Services.

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 an underlying medical condition for which such procedure, medication, facility or device was prescribed.

FDA: The United States Food and Drug Administration.

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

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

Member: An individual who is eligible and enrolled under this Agreement, and for whom Molina has received applicable first Premium payment (binder). The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21. In which case, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of Member under this Agreement but will not be a Member.

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

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

Non-Participating Provider: A Provider that has not entered into a contract with Molina to provide Covered Services to Members. Generally, except as specifically stated in this Agreement, services provided by a non-participating provider to a Member are not covered.

Other Practitioner: A Participating Provider who provides Covered Services to Members within the scope of a license but is not a Primary Care Provider or Specialist.

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

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

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

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

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), podiatrist, chiropractor, OB/GYN, certified nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under State Law and the terms of the Plan, who provides, coordinates, or helps a Member access a range of health care services.

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

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

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

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

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

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

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

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

ENROLLMENT AND ELIGIBILITY

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

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

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

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

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

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

Child or Children: The Subscriber's son, daughter, adopted child, stepchild, or foster child. Each child is eligible to apply for enrollment as a Dependent until the age of 26.

Child with a Disability: A child who reaches the age of 26 is eligible to continue to be a Dependent if the child meets the following eligibility criteria:

- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
- The child of any age is chiefly dependent upon the Subscriber for support and maintenance if the Child is permanently and totally disabled.
- A child may remain covered by Molina as a Dependent for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

Adult Dependent: A child who reaches the age of 26 is eligible to apply for enrollment as an Adult Dependent until the end of the calendar year in which the child turns the age of 30 if they are:

- 1) unmarried and do not have a Dependent of his or her own;
- 2) a resident of Florida or a full-time or part-time student; and
- 3) is not provided coverage as a named member under any other group or individual health benefit plan; or is not entitled to benefits under Title XVIII of the Social Security Act.

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

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

Spouse: A Spouse may be added as a Dependent 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 marriage to the Subscriber
- The Spouse gains status as a citizen, national, or lawfully present individual
- The Spouse permanently moves into the Service Area.

Children (Under 26 Years of Age): Children may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:

- Loss of minimum essential coverage, as defined by the Affordable Care Act
- Becomes a Dependent through marriage, birth, placement for adoption, placement in foster care, adoption, child support, or other court order.
- The Child gains status as a citizen, national, or lawfully present individual
- The Child permanently moves into the Service Area.

An adopted child's coverage shall be effective on the date of adoption, placement for adoption or as otherwise determined by the Marketplace, in accordance with applicable State Law and federal laws.

Newborn Child: A newborn child of a Subscriber is eligible as a Dependent at birth. A newborn is automatically covered for 31 days, including the date of birth. A newborn child is eligible to continue enrollment if they enrolled within Molina within 60 days.

Please note: Claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Deductible or OOPM amounts satisfied through the processing of such a newborn's claims will accrue as part of the

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

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

At 11:59 p.m. Eastern on the last day of the calendar year that the Dependent child attains age 26, unless the child has a disability and meets specified criteria (see Child with a Disability).

The date a final decree of divorce, annulment or dissolution of marriage is entered between the Dependent Spouse and Subscriber.

The date the Dependent Domestic Partner enters a termination of the domestic partnership decree from the Subscriber and Domestic Partner is entered.

For Child-Only Coverage, at 11:59 p.m. Eastern 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.

The date the Subscriber loses coverage under this Plan.

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

PREMIUM PAYMENT

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

Enter Your monthly Premium rate here: _____
The rate of payment entered above is a part of this contract in accordance with 641.31(6), F.S.

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

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

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

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

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

Grace Period: A Grace Period is a period of time after a Member’s Premium Payment is due and has not been paid in full. If a Subscriber hasn’t made full payment, they may do so during the Grace Period and avoid losing their coverage. The length of time for the Grace Period is determined by whether the Subscriber receives an APTC.

- Grace Period for Subscribers with APTCs:** Molina will provide a Grace Period of 3 consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, are receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for services in the second and third months of the Grace Period; Molina will terminate this Agreement as of 11:59 p.m. Eastern on the last day of the first month of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.
- Grace Period for Subscribers with No APTC:** Molina will provide a Grace Period of 10 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. Eastern on the last day of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

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

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

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

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

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not enrolled with Molina. Coverage for a former Member ends at 11:59 p.m. Eastern Time Zone on the day before the termination date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date.

Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within 30 days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation.

If Molina terminates a Member's membership for any reason other than non-payment of Premium or loss of eligibility, the Member will be given a 45-day advance written notice prior to coverage being terminated.

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

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

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by the Marketplace and Molina. The Marketplace will send the Member notification of loss of eligibility. Molina will also send the Member written notification when informed that the Member no longer resides within the Service Area. Coverage will end at 11:59 p.m. Eastern on the last day of the month following the month in which either of these notices is sent to the Member. The Member may request an earlier termination effective date.

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

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

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

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

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

ACCESS TO CARE

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

24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is 1 (888) 275-8750 for English and 1 (866) 648-3537 for Spanish (TTY: 711).

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

- Emergency Services
- Post Stabilization Services, unless the Member waives Balance Billing protections
- Services by a Non-Participating Provider at a Participating Facility, unless the Member waives Balance Billing protections
- Air ambulance services
- Services from a Non-Participating Provider that were previously authorized by Molina
- Exceptions described below under "Non-Participating Provider at a Participating Provider Facility"
- Exceptions described below under "No Participating Provider to Provide a Covered Service"
- Exceptions described below under "Continuity of Care" section
- Exceptions described below under "Transition of Care" section

To locate a Participating Provider, please refer to the provider directory at MolinaMarketplace.com/FLFindCare or call Customer Support. Because Non-Participating Providers are not in Molina's contracted Provider network, unless Balance Billing protections apply, they may Balance Bill Members for the difference between Molina's Allowed Amount and the rate that they charge.

Members may refer to MolinaMarketplace.com or contact Customer Support for additional information regarding protections from Balance Billing through Federal and State Law.

Member ID Card: Members should carry their Member identification (ID) card with them at all times. Members must show their ID card every time they receive Covered Services. For a replacement ID card, visit MyMolina.com or contact Customer Support. Digital versions of the ID card are available through MyMolina.com and the Molina Mobile App.

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

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

Members can request to change their PCP at MyMolina.com or by contacting Customer Support. Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP.

Sometimes a Member may not be able to get the PCP they want. This may happen because:

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

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

- Must be obtained from a Participating Provider
- Are meant to be used when care is needed now for non-emergency medical issues
- Are a method of accessing Covered Services, and not a separate benefit
- Are not permitted when the Member and Participating Provider are in the same physical location
- Do not include texting, facsimile or email only
- Covered Services provided through store and forward technology must include an in-person office visit to determine diagnosis or treatment.

Non-Participating Provider at a Participating Provider Facility: If a Member receives non-emergency care from a facility-based Non-Participating Provider who is delivering services in a Participating Provider hospital, ambulatory surgical center, or any other facility as required by federal and state law, Molina shall pay as long as the care is:

- Prior Authorized,
- Medically Necessary, and
- 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.

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 and at no greater cost to the Member than the Covered Service when rendered by a Participating Provider. Prior Authorization is required before the initiation of the service by a Non-Participating Provider in this scenario.

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;

Treatment received during the second or third trimester of pregnancy through the postpartum period, or a course of treatment received at any stage of pregnancy that is related to a pregnancy;

Any treatment being received for a terminal illness; or

An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

Continuity of care will end when the earliest of the following conditions 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:

- 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.

Referrals: A Referral is a recommendation from a Member's PCP to visit a Specialist Physician or receive certain healthcare services from a Participating Provider. The PCP and Specialist Physician will determine the care needed and coordinate services as appropriate. The PCP will issue a Referral by contacting Molina directly prior to the Specialist visit.

The Specialist Physician may discuss further testing and other services with the PCP after the Specialist visit. Tests and services not included in the Referral or performed outside the Specialist Physician's office may require a separate authorization.

Members need a Referral from their PCP to see a Specialist Physician; however, Members can see the following specialties without a Referral from their PCP:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits)
- Obstetrician and gynecologist (OB/GYN)
- Mental health or substance abuse disorder Participating Provider

Second Opinions: A Member or a Member's PCP may want another doctor (a PCP or Specialist Physician) to review the Member's condition. This doctor looks at the Member's medical record and may see the Member. This new doctor may suggest a plan of care. This is called a second opinion.

Here are some, but not all, reasons why a Member may get a second opinion:

A Member's symptoms are complex or confusing.

A doctor is not sure the diagnosis is correct.

A Member has followed the doctor's plan of care for a while, and the Member's health has not improved.

A Member is not sure that surgery is needed, or a Member thinks surgery is needed.

A Member does not agree with what the doctor thinks is the problem.

A Member does not agree with a doctor's plan of care.

A doctor has not answered the Member's concerns about a diagnosis or plan of care.

Second Opinions from Non-Participating Providers: A Member may obtain a second opinion from the provider of his or her choice, including from a Non-Participating Provider, for the following reasons:

The Member disputes Molina's or a physician's opinion of the reasonableness or necessity of surgical procedures.

The Member is seriously injured or ill.

Prior Authorization is required for a second opinion from a Non-Participating Provider. Suppose Molina authorizes a physician that is a Non-Participating Provider. In that case, Molina will pay the amount of all charges that are usual, reasonable, and customary in the community. The Member will be responsible for a coinsurance payment in the amount of 40% of the Allowed Amount. The Non-Participating Provider must be in the Molina Service Area for this product, unless Molina gives Prior Authorization for another provider. For tests deemed necessary by the physician, Molina may require the tests to be conducted by Participating Provider test facilities.

A Member may be limited to three second-opinion requests per calendar year under this product.

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

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

Physical Access: Every effort has been made to ensure that Molina's offices and the offices of Participating Providers are accessible to persons with disabilities. Members with special needs should call Customer Support for assistance finding an appropriate Participating Provider.

Access for the Speech- or Hearing-Impaired: 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 format is 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 Complaints and Appeals section of this Agreement for information regarding how to file a grievance.

PRIOR AUTHORIZATION

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

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

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

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

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

PA Timeframes

Medical Services:

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

The urgent timeframes apply if use of the standard ones:

- May seriously threaten your life or health.
- May seriously threaten your ability to regain full function.
- Would cause severe pain and cannot be managed without the requested care, according to your provider.
- **Emergency Medical Conditions and Post-Stabilization Services:** Do not need PA. However, Post-Stabilization Services received in the inpatient department of a hospital are subject to the Inpatient Concurrent Review process discussed below.

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

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

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

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

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

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

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.

COORDINATION OF BENEFITS (COB)

This provision applies when a person has health care coverage under more than one Plan. The term Plan is defined below for purposes of this section. The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

Definitions:

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by State Law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- (1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
 - (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
 - (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
 - (5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.
- E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

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

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been 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 or separated or not living together, whether or not they have ever been married: (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree; (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses

or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits; (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

- (c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:

- A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable

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

- B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

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

Facility of Payment: A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Molina will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by Molina is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

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. Cost sharing for covered prescription drugs is due at the time the network pharmacy dispenses the Member's prescription. Formulary tiering and plan design cost sharing are described in the "Prescription Drugs" section of this Agreement and Schedule of Benefits for your plan.

COVERED SERVICES

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

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

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

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB) as defined by the Affordable Care Act (ACA) and its corresponding federal regulations. Services that are not EHBs will be specifically described in this Agreement.

EHB coverage includes at least the 10 categories of benefits identified in the ACA and its corresponding federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. Eastern on the last day of the month that they turn age 19. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage.

Under the ACA and its corresponding federal regulations governing EHBs:

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

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

Approved Clinical Trials: Molina covers routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-

threatening disease or condition. A Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Members will never be enrolled in a clinical trial without their consent.

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

- 1) The study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, or a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants or
- 2) The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
- 3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

Autism Spectrum Disorder (ASD): Molina covers the diagnosis and treatment of autism spectrum disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as defined by the Diagnostic and Statistical Manual, current edition. Molina covers medically necessary treatment for autism spectrum disorders, including Applied Behavioral Analysis (ABA), prescribed or ordered by a Provider.

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

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

Dental and Orthodontic Services: Molina does not provide routine pediatric dental services under this Agreement. 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 when medically necessary
- Dental and Orthodontic services for cleft lip and 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

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

- Diabetes self-management training and education when provided by a Participating Provider
- Diabetic eye examinations (dilated retinal examinations)
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting
- Outpatient self-management training
- 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 (Type 2) screening

- Screening for gestational diabetes
- Dietician services
Nutritional counseling

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

Dialysis Services: Molina covers acute and chronic dialysis services if all the following requirements are met:

- The services are provided by a Participating Provider.
- The Members satisfies all medical criteria developed by Molina.

Emergency Services

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

Emergency Services When Out of Service Area: Members should go to the nearest emergency room for care when outside the Molina Service Area when they think they are having an Emergency. Please contact Customer Support within 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 for both Emergency Services provided by Participating Providers or Non-Participating Providers. Members should refer to the Cost Sharing for Emergency Services in the Schedule of Benefits.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services, Post-Stabilization Services, and other exceptions identified in this Agreement. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility. If the Member waives Federal Balance Billing protections and refuses the transfer, additional services provided in the Non-Participating Provider facility, including Post-Stabilization Services, are not Covered Services. Non-Covered Services may not be entitled to Balance Billing protections and the provider may balance bill Members for these services. The Member will be 100% responsible for payments, and the payments will not apply to the OOPM.

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 outside of the United States is not covered.

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

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

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

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
- Up to two hours per visit by a nurse, medical social worker, physical, occupational, or speech therapist
- Limited to 60 visits per calendar year

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. Molina also covers respite care up to seven

days per occurrence. Respite is short-term inpatient care provided in order to give relief to a person normally providing care.

Inpatient Hospital Services: Members must have a Prior Authorization before receiving covered hospital services, except in the case of Emergency and Post-Stabilization Services. Post-Stabilization Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered provided the Member's coverage with Molina has not terminated and the Member has not waived Balance Billing protections pursuant to Federal Law. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

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

Mental Health Services (Inpatient and Outpatient): Molina covers a continuum of Mental Health Services when provided by Participating Providers and facilities acting within the scope of their license. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria. Molina may require authorization for coverage of services, including inpatient and certain outpatient services. The concurrent review authorization process applies to all involuntary admissions. See the "Inpatient Concurrent Review" section of this Agreement for more information.

A mental disorder is a mental health condition identified in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental disorders covered under this Agreement may include severe mental illness of a person of any age. Severe mental illness includes the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa.

Molina does not cover career, marriage, parental or job counseling or therapy. In addition, treatment or testing within an inpatient setting related to Pervasive Developmental Disorders, including autism spectrum disorder, learning disabilities, and/or cognitive disabilities are not covered. Molina does not cover services for mental health conditions that the DSM identifies as something other than a Mental Disorder.

Molina generally covers the following Medically Necessary Mental Health Services:

- Inpatient care

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

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

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

- Office visits, including:
 - Associated medical supplies
 - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician's office, an outpatient or an inpatient setting.
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy (covered based on the type of service and where it is received)
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care.
- Sleep studies (Separate facility Cost Sharing may apply)
- Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals
- Services of an optometrist, ophthalmologist or registered Nurse Anesthetist when practicing within the scope of his or her license.
- Child health supervision services for Dependent children from birth to 16 years of age that:
 - Are physician-delivered or physician-supervised services
 - May include, at a minimum, services delivered at the intervals and scope required by law
 - Must include periodic visits that include:
 - A history
 - A physical examination
 - A developmental assessment and anticipatory guidance
 - Appropriate immunizations and laboratory tests

Such services and periodic visits must be limited to those that are required by the prevailing medical standards. Such services and periodic visits must be consistent with the "Recommendations for Preventive Pediatric Health Care" of

the American Academy of Pediatrics. Visits are limited to one visit payable to one Participating Provider for all of the services provided at each visit.

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

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia
- Laboratory services
- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that Members or Member's Provider notifies Molina.
- Services provided by licensed birthing centers and by certified nurse-midwives and licensed midwives working within the scope of their licenses

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

Pregnancy Termination: Molina only covers pregnancy termination services before the gestational age of the fetus is less than 15 weeks to the extent required by the Affordable Care Act, federal law, and by any State Law, unless one of the following conditions is met

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.
 - One physician can also certify the above in writing when a second physician is unavailable for consultation and there is medical necessity for legitimate emergency medical procedures for termination of the pregnancy for the reasons stated above.
- The fetus has not achieved viability under state law and two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality.

Note: Pregnancy termination services that are provided in an inpatient hospital setting require Prior Authorization.

Preventive Services: In accordance with 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 evidence-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: uspreventiveservicestaskforce.org; Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); Preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF; and Mammograms as follows:

- A baseline mammogram for any Member who is 35 to 40 years of age;
- A mammogram every 2 years for any Member who is 40 to 50 years of age, or older, or more frequently based on the Member’s Provider’s recommendations;
- A mammogram every year for any Member who is 50 years of age or older;
- One or more mammograms a year, based upon a Provider’s recommendation for any Member who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a Member has not given birth before the age of 30.

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

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the ACA, its corresponding federal regulations and applicable State Law.

Prosthetic, Orthotic, Internal Implanted and External Devices: Molina covers the prosthetic and orthotic devices described in this section if all of the following requirements are met:

The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes;

The device is the standard device that adequately meets the Member’s medical needs; and

The Member receives the device from the provider or vendor that Molina selects.

Coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether the Member needs a prosthetic or orthotic device. If Molina covers a replacement device, then the Member pays the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices: Molina covers internally implanted devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by Molina. Please refer to the “Inpatient Services” or “Outpatient Services” sections (as applicable) of the Schedule of Benefits to see the Cost Sharing applicable to internally implanted devices.

External devices: Durable Medical Equipment Cost Sharing applies for the following external prosthetic and orthotic devices.

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

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

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

The following reconstructive surgery services are not covered:

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

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Outpatient rehabilitative services are limited to a total of 35 visits for any combination of the following therapies; however, only 26 of those visits can be for Spinal Manipulative Therapy:

- Cardiac Rehabilitation Therapy
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Massage Therapy by licensed massage therapist
- Spinal Manipulative Therapy

Skilled Nursing Facility: Molina covers 60 days per Plan 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. Molina may require authorization for coverage of services, including inpatient and certain outpatient services. Molina covers the following outpatient care for treatment of substance use disorder:

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

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

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

Inpatient surgical services include:

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

Outpatient surgery services provided in any of the following locations:

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

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

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

The condition is caused by a congenital, developmental or acquired deformity, disease or injury.

Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

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

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

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

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

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

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

Laser corrective surgery is not covered.

PRESCRIPTION DRUGS

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

Pharmacies: Molina covers drugs at retail pharmacies, specialty pharmacies, and mail order pharmacies within our networks. Members may be required to fill a drug with a contracted specialty pharmacy if the drug is subject to Food and Drug Administration (FDA) restrictions on distribution, requires special handling or provider coordination, or if specialized patient education is required to ensure safe and effective use. To find network pharmacies, please visit MolinaMarketplace.com/FLFindCare. A hardcopy is also available upon request made to Customer Support.

Molina Formulary: Molina establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the "Formulary." The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members at MolinaMarketplace.com/FLFormulary2024. A hardcopy is also available upon request. The list of products on the Formulary is chosen by a group of medical professionals from inside and outside of Molina. This group reviews the Formulary regularly and makes changes every three months based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs.

Access to Nonformulary Drugs: The Formulary lets Members and their Prescribers know which products are covered by the Plan's pharmacy benefit. The fact that a drug is listed on the Formulary does not guarantee that a Prescriber will prescribe it for a Member.

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

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

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

Any request that is not considered an expedited exception request is considered a Standard Exception request.

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

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

24 hours following receipt of an expedited exception request

72 hours following receipt of a standard exception request

If the request is denied, Molina will send a letter to the Member or their representative, and the Prescriber. The letter will explain why the drug or product was denied. It is within the Member's rights to purchase the drug at the full cost charged by the pharmacy. If the Member disagrees with the denial of the request, the Member, their representative, or Prescriber can appeal Molina's decision. The Prescriber may request to talk to Molina reviewers about the denial.

If an internal appeal of the original coverage determination is requested, Molina will notify the Member, their representative, and the Prescriber, of the internal appeal decision no later than:

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

The Member or their representative, or the Prescriber may also request that an Independent Review Organization (IRO) review Molina's internal appeal decision. The Member or their representative, and the Prescriber, will be notified of the IRO decision no later than:

24 hours following receipt of an appeal on a denied expedited exception request

72 hours following receipt of an appeal of a denied standard exception request

Cost Sharing: Molina puts drugs on different levels called tiers, Preventative Drugs through Brand and Generic Specialty Drugs, based on how well they improve health and their value compared to similar treatments. The Schedule of Benefits shows Member Cost Share for a one-month supply based on these tiers.

Here are some details about which drugs are on which tiers:

Drug Tier	Description
Preventative Drugs	Nationally recognized preventive service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with \$0 Cost Sharing; additional drugs with \$0 Cost Sharing where applicable.
Preferred Generic Drugs	Preferred generic drugs; lowest Cost Sharing.
Preferred Brand Drugs	Preferred brand-name drugs; higher Cost Sharing than preferred generic drugs.
Non-Preferred Drugs	Non-preferred brand-name and generic drugs; higher Cost Sharing than preferred brand-name and generic drugs used to treat the same conditions.
Specialty Drugs	Specialty drugs (brand-name and generic); Drugs that require special handling, complex counseling or monitoring, limited distribution, or other special pharmacy requirements. Higher Cost Sharing than non-specialty drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use a network specialty pharmacy.
DME	Durable Medical Equipment (“DME”) - Cost Sharing applies; some non-drug products on the Formulary have Cost Sharing determined by the DME coinsurance.

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

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

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

or home infusion service, and will help the Member coordinate and transition through case management.

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

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

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

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

Prescription Drugs to Stop Smoking: Molina covers a three-month supply of drugs to help Members stop smoking, with no Cost Share. Members should consult their Provider to determine which drug is right for them. Covered drugs are listed on the Formulary.

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

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

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

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs and their administration. Prior authorization requests for drugs to be used outside the FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity. These requests are reviewed against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on non-FDA label use. Chemotherapy drugs obtained in the Provider's office will be subject to medical benefit cost sharing, while those obtained at the pharmacy will be subject to pharmacy benefit cost sharing. Please refer to the Schedule of Benefits for applicable Cost Sharing. Most new anti-cancer drugs are considered the Brand and Generic Specialty Drugs Tier under the pharmacy benefit. Certain anti-cancer drugs are covered under a partial fill program. Network pharmacies may dispense newly started anti-cancer drugs half a month's supply at a time for the first several fills until Members are stable on the drug and dose.

Treatment of Human Immunodeficiency Virus (HIV): Molina covers prescription drugs for the treatment of HIV infection, or an illness or medical condition arising from or related to HIV. Drugs must be prescribed within the Provider's scope of practice and approved by the United States Food and Drug Administration (FDA), including Phase III experimental or investigational drugs that are FDA approved and are administered according to protocol. Members' share of the cost for certain categories of brand and generic drugs is limited to the cost sharing set by the formulary tier or the maximum amount set by Florida Safe Harbor guidelines, whichever is lower.

Mail Order Availability of Formulary Drugs: Molina offers Members a mail order option for certain drugs in the Preventative Drugs, Preferred Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand and Generic Drugs Tiers. Eligible drugs are marked "MAIL" on the Formulary. Formulary drugs can be mailed to a Member within 10 days from order request and approval. Through this option, Members can get a 3-month supply of eligible drugs at reduced Cost Sharing. Cost Sharing for a 3-month supply through mail order is applied at a rate of two-and-a-half times the one-month supply Cost Sharing at the drug's Formulary tier. Brand and Generic Specialty Drugs Tier drugs are not eligible for 90-day supply programs like Mail Order, though most Specialty medications will be shipped to the Member directly. Refer to MolinaMarketplace.com/FLFormulary2024 or contact Member Services for more information.

Off-Label Drugs: Molina will not deny coverage of off-label drug use solely on the basis that the drug will be used outside of the FDA-approved labeling. Molina does cover off-label drug use to treat a covered, chronic, disabling, or life-threatening illness. The drug must be approved by the FDA for at least one indication. The use must be recognized

as standard and effective for treatment of the indication in any of the standard drug reference compendia or substantially accepted peer-reviewed medical literature. Molina may require that other treatments that are also standard have been tried or are not clinically appropriate if permitted under State Law. The off-label drug use request must demonstrate Medical Necessity to treat a covered condition when Prior Authorization is required.

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

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

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

- Cosmetic services
- Hair loss or growth treatment
- Infertility (other than treating an underlying diagnosis which caused infertility)
- Erectile dysfunction
- Sexual dysfunction
- Weight loss drugs, or diabetic drugs when used off-label to lose weight instead of treating diabetes

EXCLUSIONS

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

Acupuncture Services: Acupuncture services are not covered.

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

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

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

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

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

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

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

Dietitian: A service of a dietician is not a covered benefit. This exclusion does not apply to services under hospice care.

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

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

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

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

Infertility Services: Molina does not cover infertility services and supplies, including insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

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

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

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills, teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching Members how to read if they have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional-growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy
- Examinations related to job, athletic (sports physicals), or recreational performance

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

Massage Therapy: Massage therapy is not covered.

Non-Emergent Services Obtained in an Emergency Room: Generally, and unless stated otherwise in this Agreement, services provided within an emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered.

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

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

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

- A Hospital,
- A skilled nursing facility,
- Inpatient respite care covered in the "Hospice Services" 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 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 not approved by the FDA are not covered. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to services covered under Approved Clinical Trials section. Please refer to the Complaints and Appeals section for information about denied requests for Experimental or Investigational services.

Services Provided Outside the Service Area: Except as otherwise provided in this Agreement, any services and supplies provided to a Member outside the Service Area where the Member traveled to the location to receive medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. When a 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 as 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 unless stated otherwise in this Agreement. If a Member later suffers a life-threatening complication such as a serious infection, this exclusion will not apply. Molina would cover any services that Molina would otherwise cover to treat that complication.

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

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

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

CLAIMS

Filing a Claim: Providers must promptly submit to Molina claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Molina and must include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Member or Provider to Molina within 6 months 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 90 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 eligible for payment, and Provider waives any right to payment.

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

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

For covered medical services, Members must mail this information to Molina Customer Support at the address on the first page of this Agreement. The Member will need to mail Molina a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number.

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

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

The Member asks for and gets medical services that are not Covered Services.

Except in the case of Emergency Services, the Member asks for and gets healthcare services from a Provider or facility that is a Non-Participating Provider without getting a prior approval from Molina.

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

LEGAL NOTICES

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

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

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

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

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

Non-Discrimination: Molina does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity, or genetic information.

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

Non-Assignment: A Member, a legal representative, or someone acting on the Member's behalf cannot assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder. The foregoing will not preclude for a Member to authorize Molina, in writing, the direct payment of certain benefits payable to a Provider for covered serviced provider under the Agreement.

No Third-Party Beneficiaries: This Agreement does not create, nor is intended to create or grant any rights in favor of any third party, including Providers. This Agreement shall not be construed to create any third-party beneficiary rights.

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

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

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

Time Limit on Certain Defenses: Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period. No claim for loss incurred or disability commencing after 2 years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Agreement.

Time Limit on Legal Actions: If the Member would like to bring legal action, must do so within one year of the date Molina notified the Member of the final determination of any complaint, grievance or appeal.

Wellness and Other Program Benefits: This Agreement includes access to a wellness program to encourage Members to complete health activities that support their overall health. The program is voluntary and available to all Subscribers at no cost. The

program is additionally available to Dependents 18 years and older at no cost. Molina may offer you rewards or other benefits for participating in certain health activities and programs. The rewards and program benefits available to you may include premium credits or other benefits such as gift cards.

Members should consult with their PCP before participation. The wellness program is optional, and the benefits are made available at no additional cost to eligible members. Rewards and program benefits are available for redemption only while the Subscriber or eligible Dependent is currently enrolled with a Molina marketplace health plan. For more information, please contact Customer Support.

BINDING ARBITRATION

OPTION TO RESOLVE ALL DISPUTES EXCEPT MEDICAL MALPRACTICE BY BINDING ARBITRATION

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

If Member and Molina agree to arbitrate, any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this product (except for claims of medical malpractice which would be governed by Chapter 766 of the Florida Statute (“F.S.”) and which are expressly excluded) between Member (including any heirs, successors or assigns of the Member) and Molina, or any of its parents, subsidiaries, affiliates, successors or assigns may be submitted to binding arbitration in accordance with applicable state and federal laws, including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, the Florida Arbitration Act, Chapter 682 F.S. et seq., and the Affordable Care Act. Any such dispute will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Arbitration shall not preclude review pursuant to Rule 69O-191.081 of the Florida Administrative Code. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

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

The final and binding arbitration shall be conducted in accordance with the American Arbitration Association (AAA) Commercial Arbitration Rules and

Mediation Procedures, and administration of the arbitration shall be performed by the AAA or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the AAA Commercial Arbitration Rules and Mediation Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration in accordance with the Florida Arbitration Act. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Florida state law court, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. Proceeding with binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.

The parties shall divide equally the costs and expenses of the AAA and the arbitrator. In cases of extreme hardship, Molina may assume all or part of the Member's share of the fees and expenses of AAA and the arbitrator, provided the Member submits a hardship application to the AAA. The hardship application shall be made in a manner and with the information and any documentation as required by the AAA. The AAA (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

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

IN PROCEEDING WITH ARBITRATION, THE PARTIES WILL WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED BEFORE A JURY AND WOULD INSTEAD ACCEPT THE USE OF BINDING ARBITRATION.

COMPLAINTS AND APPEALS

COMPLAINTS: If a Member has a problem with any Molina services, Molina wants to help fix it. Members may call Molina Customer Support toll-free at the number shown on the Welcome page of this Agreement.

Members may also send a problem or complaint in writing, along with any supporting materials, by mail or fax to the following:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O. Box 36030
Louisville, KY 40233-6030
Fax: 1-877-508-5748
MFLGrievanceandAppealsDepartment@MolinaHealthCare.Com
MolinaMarketplace.com

Members may also contact the Florida Department of Financial Services at:

Florida Department of Financial Services
Division of Consumer Services
200 E. Gaines Street
Tallahassee, FL 32399-0322
Toll-free: 1 (877) 693-5236
TTY: 711

GRIEVANCES: A grievance is a written complaint submitted by a Member or on a Member's behalf to Molina or to a state agency regarding the:

Availability, coverage for the delivery, or quality of health care services;
Claims payment, handling, or reimbursement for health care services; or
Matters pertaining to the contractual relationship between the Member and Molina.

Molina will provide the grievance procedure upon request for the purpose of addressing complaints and grievances. Members must submit a grievance within one year after the date of occurrence of the action that initiated the grievance.

APPEALS

Definitions

The capitalized terms used in this appeals section have the following definitions.

“Adverse Benefit Determination” means:

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit;
Any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay, or other health care service does not meet Molina's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness; or

Based in whole or in part on medical judgment, includes the failure to cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.

A decision by Molina to deny coverage based upon an initial eligibility determination.

An Adverse Benefit Determination also includes a rescission of coverage and applicability of State or Federal Surprise Billing protections, as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required Premiums or contributions toward cost of coverage.

The denial of payment for services or charges (in whole or in part) pursuant to Molina's contracts with network providers, where Members are not liable for such services or charges, is not an Adverse Benefit Determination.

"Authorized Representative" means an individual authorized in writing by a Member or state law to act on the Member's behalf in requesting a health care service, obtaining claim payment, or during the internal appeal process. A health care provider may act on behalf of a Member without the Member's express consent when it involves an Urgent Care Service.

"DFS" means the Florida Department of Financial Services.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination that is upheld after the internal appeal process.

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

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

"Urgent Care Services Claim" means an Adverse Benefit Determination was rendered and the requested service has not been provided, where the application of non-urgent care appeal time frames:

Could seriously jeopardize the Member's life or health or unborn child; or
In the opinion of the treating physician, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Internal Appeal

A Member or a Member's Authorized Representative or a treating Provider or facility may submit an appeal of an Adverse Benefit Determination. Molina will provide the Member with the forms necessary to initiate an appeal.

A Member may request these forms by contacting Molina Customer Support toll-free at the number shown on the Welcome page of this Agreement. While Members are not required to use Molina's pre-printed form, Molina strongly encourages that an appeal be

submitted on such a form to facilitate logging, identification, processing, and tracking of the appeal through the review process.

If Members need assistance in preparing the appeal, or in submitting an appeal verbally, they may contact Molina for such assistance at:

Molina Healthcare of Florida
 Appeal and Grievance Unit
 P.O Box 36030
 Louisville, KY 40233-6030
 Fax: 1-877-508-5748
 MFLGrievanceandAppealsDepartment@MolinaHealthCare.Com
 MolinaMarketplace.com

A Member or Authorized Representative must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination.

Within five business days of receiving an appeal, Molina will send the Member or Authorized Representative a letter acknowledging receipt of the appeal.

The appeal will be reviewed by personnel who were not involved in the making of the Adverse Benefit Determination. It will include input from health care professional in the same or similar specialty as typically manages the type of medical service under review.

TIME FRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	TIME FRAME FOR DECISION
Urgent Care Service	Within 72 Hours
Pre-Service Authorization	Within 30 Days
Concurrent Service (A Request to Extend or a Decision to Reduce a Previously Approved Course of Treatment)	Within 72-Hours for Urgent Care Services and 30-Days for Other Services
Post-Service Authorization	Within 60 Days

A Member’s coverage will remain in effect pending the outcome of an internal appeal.

External Appeal

After Members have exhausted the internal appeal rights provided by Molina, they have the right to request an external/independent review of an Adverse Benefit Determination. A Member or Authorized Representative may file a written request for an external review.

The notice of Adverse Benefit Determination and Final Adverse Benefit Determination describes the process to follow if a Member wishes to pursue an external appeal.

Members must submit their request for external review within 4 months of the date they receive a notice of Adverse Benefit Determination or Final Adverse Benefit Determination.

Members can request an external appeal by fax at 1 (888) 866-6190, online at externalappeal.com or by mail at:

MAXIMUS Federal Services
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

If a Member has any questions or concerns during the external appeal process, the Member or Authorized Representative can call the toll-free number 1 (888) 866-6205. The Member or Authorized Representative can submit additional written comments to the external reviewer at the mailing address above.

If any additional information is submitted, it will be shared with Molina in order to give Molina an opportunity to reconsider the denial.

Request for expedited external appeal

A Member or Authorized Representative may make a written or oral request for an expedited external appeal with the external reviewer when the Member receives:

An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an appeal of an Urgent Care Service would seriously jeopardize the Member's life or health or would jeopardize the ability to regain maximum function and the Member has filed a request for a review of an Urgent Care Service; or

A Final Adverse Benefit determination, if the Member has a Medical Condition where the timeframe for completion of a standard external review would seriously jeopardize the Member's life or health or would jeopardize the ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility; or

An Adverse Benefit Determination that relates to Experimental or Investigational treatment, if the treating physician certified that the recommended or requested health care service, supply, or treatment would be significantly less effective if not promptly initiated.

In expedited external appeal situations, requests for expedited review can be initiated by calling MAXIMUS Federal Services toll free at 1 (888) 866-6205, or by faxing the request to 1 (888) 866-6190, or by mailing the request to:

MAXIMUS Federal Services
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Additionally, upon a Member's request, Molina can send the Member copies of the actual benefit provision, and will provide a copy at no charge, of the actual benefit, clinical guidelines or clinical criteria used to make the determination upon receipt of the request. A request can be made by calling the Molina Complaints and Appeals Coordinator.

Exhaustion of Process

The foregoing procedures shall be mandatory and must be exhausted before initiating litigation or arbitration against Molina.

General Rules and Information

General rules regarding Molina's Complaint and Appeal Process include the following:

A Member must cooperate fully with Molina in Molina's effort to promptly review and resolve a complaint or appeal. In the event a Member does not fully cooperate with Molina, the Member will be deemed to have waived the right to have the Complaint or Appeal processed within the time frames set forth above. Molina will offer to meet with a Member by telephone. Appropriate arrangements will be made to allow telephone conferencing to be held at Molina's administrative offices. Molina will make these telephone arrangements with no additional charge to the Member.

During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.

Molina will provide the Member with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when the initial Adverse Benefit Determination was made. A "full and fair" review process requires Molina to send any new medical information to review directly so the Member has an opportunity to review the claim file.

Telephone Numbers and Addresses

Members may contact a Molina Complaints and Appeals Coordinator at the number listed on the acknowledgment letter or notice of Adverse Benefit Determination or Final Adverse Benefit Determination. Below is a list of phone numbers and addresses for complaints and appeals.

Department of Financial Services
Division of Consumer Services
200 E. Gaines Street
Tallahassee, FL 32399-0322
Toll-free: 1 (877) 693-5236
TTY: 711

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030
Fax: 1-877-508-5748
MFLGrievanceandAppealsDepartment@MolinaHealthCare.Com
MolinaMarketplace.com

Your Extended Family.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ուժեղացրե՛ք Ձեր լեզվով օգնություն կարիք ունեց. գտնված է Member Services: Համարը գտնվում է Ձեր Member ID քարտի ետևի մասում: (TTY: 711):

Անկա են կանել հաշմանդամություն ունեցող անհատից համար կախման օգնություն և ծառայություններ, ինչպես բրեյլի և մեծ տպագրանակի փաստաթղթեր: Այս ծառայությունները անվճար են: (Armenian)

ការយកចំនុចកម្ពុជា ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការភ្នែកជាងគ្នា គឺជា អង្គការសុខភាពសាធារណៈ ប្រទេសកម្ពុជា ប្រើប្រាស់លេខស្រីស្រី ៧១១ ដើម្បីជំនួយជនពិការភ្នែក។

ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការហៅកាត់សេវាកម្មសម្រាប់ជនពិការភ្នែក ឬជនមានទីកាំងនៅខាងក្រោយអន្តរាគមន៍ប្រជាជនកម្ពុជា, (TTY: ៧១១), សេវាកម្មទាំងនេះដោយមិនគិតថ្លៃ, (Cambodian)

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

توجه: کمک ها و خدمات برای افراد معلول, مانند اسناد بریل

و چاپ بزرگ نیز در دسترس هستند. در صورت نیاز به کمک در زبان خود با خدمات عضو واقع در پشت کارت شناسایی خود

تماس بگیرید(Farsi). این خدمات رایگان هستند. (TTY: 711)

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

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

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

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

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

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

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

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

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

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

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

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

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

ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโทรติดต่อฝ่ายบริการสมาชิก

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

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711).

Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711).

Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)