Molina Healthcare of Ohio Marketplace

2026

Agreement and Combined Evidence of Coverage and Disclosure Form

Molina Healthcare of Ohio
3000 Corporate Exchange Dr.
Columbus, OH 43231

MHO01012026 – DENTAL + VISION
OH26EOCE_DV

NOTICE: SUBSCRIBER HAS THE RIGHT TO RESCIND THIS MOLINA HEALTHCARE OF OHIO, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE (THE “AGREEMENT”) UNTIL MIDNIGHT OF THE TENTH DAY AFTER THE DATE HE OR SHE RECEIVED THIS AGREEMENT. IF SUBSCRIBER RESCINDS THE AGREEMENT DURING THAT PERIOD, WE WILL CHARGE THE SUBSCRIBER PREMIUM FOR THE NUMBER OF DAYS THAT THE AGREEMENT WAS IN EFFECT. THIS RIGHT TO RESCIND ENDS IF ANY MEMBER MAKES A CLAIM FOR BENEFITS OR RECEIVES COVERED SERVICES BEFORE THE RIGHT TO RESCIND IS EXERCISED. TO RESCIND THIS POLICY, RETURN THIS AGREEMENT TO:

MOLINA HEALTHCARE OF OHIO, INC.
PO BOX 349020
COLUMBUS, OH 43234-9020

PLEASE TELL US YOUR NAME AND THAT YOU WANT TO RESCIND THE AGREEMENT, ALTHOUGH YOU DO NOT NEED TO TELL US WHY.

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

MEDICARE ADVISORY: THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM THE COMPANY.

Service Area: Counties of Adams, Allen, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Trumbull, Union, Van Wert, Vinton, Warren, Wayne, Wood, Wyandot

Thank You for Choosing Molina

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

We're providing you this 2025 Molina of Ohio 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 or visit MolinaMarketplace.com or 1 (888) 296-7677.

We look forward to serving you,

Molina Marketplace

WHERE TO GO FOR CARE AND HELP

Service	Need	Where to Go
Emergency Room	You should go to the ER for sudden injury or sickness such as: • A lot of bleeding • A very bad burn • Trouble breathing • Drug overdose • Chest pain • Broken bones	Go to the nearest Emergency Room or call 911 if you have an emergency.
Urgent Care	Urgent Care Centers treat medical problems that may not wait until your next doctor's visit but are not life threatening. • Twisted or sprained ankle • Cough, cold, sore throat • Cuts, bumps and sprains • Fever or flu symptoms • General wound care	Molina has a network of Urgent Care facilities. To find your nearest in-network Urgent Care visit MolinaHealthcare.com/ProviderSearch
Getting Care	• Primary Care • Virtual Care • After-Hour Care	• Your Primary Care Provider is your main healthcare provider in non-emergency situations. Your annual visit is always covered. To search for an in-network provider near you visit MolinaHealthcare.com/ProviderSearch • See a doctor from anywhere, anytime virtually with Teladoc. Visits are unlimited and covered under your plan. Visit Teladoc.com/molinamarketplace to sign up and schedule an appointment. • Highly trained nurses are available to assist you 24 hours a day. Call the 24-hour Nurse Advice Line 1 (888) 275-8750 (English) or 1 (866) 648-3537 (Spanish)
Self Service for your Account	• Find or change a doctor • View benefits and Member Handbook • View or print ID card	• Make an account on MyMolina.com to access your Member Portal. • Download the Molina Mobile App for healthcare on-the-go.

	• Track claims • Make a payment or sign up for Autopay	• Go to Molinapayment.com to make a one-time payment.
Plan Details	• Answers about this Plan, programs, services, or prescription drugs • ID card support • Access to care • Payment questions	**Molina Customer Support** 1 (888) 296-7677 Monday through Friday, 8:00 a.m. to 6:00 p.m. ET **Go to** MyMolina.com
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report changes of address or income	**Go to** HealthCare.gov 1 (800) 318-2596

TABLE OF CONTENTS

WHERE TO GO FOR CARE AND HELP 4

TABLE OF CONTENTS 6

DEFINITIONS 11

ENROLLMENT AND ELIGIBILITY 17

Open Enrollment Period 17
Special Enrollment Period 17
Child-Only Coverage 17
Dependents 17
- Spouse 17
- Child or Children 17
- Child with a Disability 17
- Domestic Partner 18

Adding New Dependents 18
- Spouse 18
- Children (Under 26 Years of Age) 18
- Adopted or Newborn Child 18
- Court Order or Child Support Order 19
- Foster Child 19

Discontinuation of Dependent Coverage 19
Continued Eligibility 19
Option for Conversion 19

PREMIUM PAYMENT 21

Advanced Premium Tax Credit (APTC) 21
Payment 21
Third Party Payment of Premium and Cost-Sharing 21
Late Payment Notice 21
Grace Period 21
- Grace Period for Subscribers with APTCs 21
- Grace Period for Subscribers without APTC 22

Termination Notification for Nonpayment 22
Reinstatement After Termination 22
Re-enrollment After Termination for Nonpayment 22
Renewability of Coverage 22

TERMINATION OF COVERAGE 23

Ineligibility of Dependent and Child-Only Coverage Due to Age 23
Member Ineligibility 23
Nonpayment of Premium 23
Fraud or Intentional Misrepresentation 23
Member Disenrollment Request 23
Discontinuation of a Particular Product 24
Discontinuation of All Coverage 24

CONTINUITY OF CARE 25

ACCESS TO CARE 27

Telehealth Services 28
Accessing Care for Members with Disabilities 29

PRIOR AUTHORIZATION 31

Utilization Review 32
Concurrent Review 32
Referral 33
Second Opinion 33

COORDINATION OF BENEFITS (COB) 34

COST SHARING 40

COVERED SERVICES 41

Essential Health Benefits 41
Basic Health Care Services 42
Mental Health Parity and Addiction Equity Act 42
Approved Clinical Trials 42
Autism Spectrum Disorder (ASD) 44
Cancer Treatment 44
Complex Case Management 45
Dental and Orthodontic Services 45
Diabetes Services 45
Dialysis Services 46
Emergency Services: 46
Emergency Services Rendered by a Non-Participating Provider 46
Emergency Transportation Services 47
Family Planning 47
Habilitation Services 48
Hearing Aids and Related Services 48
Home Healthcare 49
Home Infusion Therapy 49
Hospice Services 50
Infertility Services 50
Inpatient Hospital Services 50
Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services 50
Mental Health Services (Inpatient and Outpatient) 50
Physician Services 51
Pregnancy and Maternity 52
Pregnancy Termination 52
Preventive Services 53
Prosthetic, Orthotic, Internal Implanted and External Devices 54
Reconstructive Surgery 55
Rehabilitation Services 55
Routine Adult Dental Services (age 19 and older) 55
Skilled Nursing Facility 63
Substance Use Disorder (Inpatient and Outpatient) 64
Surgery (Inpatient and Outpatient) 64
Temporomandibular Joint Syndrome ("TMJ") Services 65
Urgent Care Services 65
Vision Services (Adult and Pediatric) 65

PRESCRIPTION DRUGS 67

Drugs, Medications and Durable Medical Equipment 67

Pharmacies 67
Molina Formulary 67
Access to Nonformulary Drugs 67
Requesting an Exception 68
Cost Sharing 69
Cost Sharing on Formulary Exceptions 69
Site of Care for Provider-administered Drugs Required Program 69
Drug Cost Sharing Assistance and Out-of-Pocket Costs 70
Over-the-Counter Drugs, Products, and Supplements 70
Durable Medical Equipment (DME) 70
Diabetic Supplies 70
Prescription Drugs to Stop Smoking 70
Day Supply Limit 71
Proration and Synchronization 71
Opioid Analgesics for Chronic Pain 71
Drugs to Treat Cancer 71
Treatment of Human Immunodeficiency Virus (HIV) 72
Extended Day Supply Availability of Formulary Drugs 72
Off-Label Drugs 72
Pharmacy Benefits Practices 72
Non-Covered Drugs 72

EXCLUSIONS 74

Provider-to-Provider Consultation 76

CLAIMS 79

Filing a Claim 79
Claim Processing 79
Member Reimbursement 79
Paying Bills 80

LEGAL NOTICES 81

Third-Party Liability and Subrogation 81
Molina's Right of Reimbursement 81
Molina's Rights Take Priority 81
Worker's Compensation 82
Acts Beyond Molina's Control 82
Waiver 82
Non-Discrimination 82
Genetic Information 82
Agreement Binding on Members 82
Assignment 83
Governing Law 83
Invalidity 83
Notices 83
Legal Action 83
Time Limit on Certain Defenses 83
Wellness and Other Program Benefits 83
Annual Health Activity 84
Incarcerated Insured 84
Availability of Medicaid 84
Availability of Medicare 84
Health Education Materials 84

Physical Examination and Autopsy 84
Alcohol or Drug Related Injury 84
Cancellation by the Member 84
Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act 84
Balance Billing 85

CLAIMS DECISIONS, COMPLAINTS, INTERNAL AND EXTERNAL APPEALS 86

Complaints 86
Appointing a Representative 87
Urgent Care Service Claim 87
Initial Denial Notices 87
Internal Appeals 88
Appeals Denial Notices 90
External Review 91
Standard External Review 91
Expedited External Review 91
External Review of Experimental and Investigational Treatment 92
IRO Assignment 92
IRO Review and Decision 93
Binding Nature of External Review Decision 93
Ohio Department of Insurance External Review 93

Policy Issuance: This Molina Healthcare of Ohio, Inc. Agreement and Individual Evidence of Coverage (also called the "Agreement") is issued by Molina Healthcare of Ohio, 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 to waive any of its provisions.

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

Interpreter Services: Molina offers interpreter services to assist any Member who may require language support in understanding and obtaining health coverage under this Agreement. Molina provides these services at no additional cost to the Member. Molina offers both oral interpretation and written translation services for materials vital for a Member's understanding their health care coverage. Members who are deaf or hard of hearing can use the Telecommunications Relay Service by dialing 711.

DEFINITIONS

Some words or terms in this Agreement may not have their usual meanings. Health plans often use these words in a specific way. If a word with a specialized meaning appears in only one section of this Agreement, it will be defined in that section. Words with special meanings used in any section of this Agreement are capitalized and are explained in this "Definitions" section.

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

Affordable Care Act ("ACA"): The comprehensive health care reform law enacted in March 2010, also referred to as "PPACA" or "Obamacare".

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

- *Services obtained from a Participating Provider*: Will be reimbursed at the contracted rate (the amount agreed for as compensation for rendering services between Molina and our Participating Provider) for such Covered Services.

- *Emergency Services, Emergency Transportation Services, and Unanticipated Out-of-Network Care received from a Non-Participating Provider:* Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of:
  1) Molina's median contracted rate for such service(s) within the geographic region,
  2) The amount that would be paid under the Medicare program for such service(s), or
  3) The amount determined by Molina's typical out-of-network reimbursement methodology, as detailed below with regard to "All Other Covered Services Received from a Non-Participating Provider."

  Please note: Emergency Services, Emergency Transportation Services, and Unanticipated Out-of-Network Care obtained for treatment of an Emergency Medical Condition from Non-Participating Providers are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits calculated at the in-network level. Members will not be Balance Billed for Emergency Services, Emergency Transportation Services, or Unanticipated Out-of-Network Care rendered by Non-Participating Providers.

- *Post-Stabilization Services*: The Allowed Amount shall be the lesser of the Provider's charged amount and the qualifying payment amount, as defined by

federal law. Cost-sharing for Post-Stabilization Services is subject to the Cost-Sharing for Emergency Services in the Schedule of Benefits calculated at the in-network level. Members will not be Balance Billed for Post-Stabilization Services unless they consent to waive Balance Billing protections according to the required process under federal law.

- *All Other Covered Services Received from a Non-Participating Provider:* Unless Molina and the non-participating provider agree on a negotiated amount, all other covered services will be paid at the lesser of the following, provided all other terms of this Agreement are followed:
    - Molina's median contracted rate for such service(s); or
    - 100% of the published Medicare rate for such service(s).

Annual Out-of-Pocket Maximum (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. 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 self-only coverage under this Agreement and a separate OOPM amount for all other coverage when there are two or more Members enrolled ("combined OOPM"). When two or more Members are enrolled under this Agreement:

1) the self-only OOPM will be met, with respect to the subscriber or a Dependent, when that person meets the self-only OOPM amount; or
2) the combined 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 family members 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 billed charges and the Member's Cost Sharing amount. A Molina Participating Provider is not permitted to Balance Bill a Member for Covered Services. Non-Participating Providers may Balance Bill Members unless there are Balance Billing protections through federal or State Law.

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

Coinsurance: The percentage of costs for Covered Services that a Member is responsible for. 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 that the Member will pay for a Covered Service. If applicable, Copayments are listed in the Schedule of Benefits.

Cost Sharing: The portion of costs that a Member is responsible for paying out of their own pocket for Covered Services. Generally, this term includes Deductibles, Coinsurance, and Copayments, but it does not include Premiums, Balance Bill amounts for Non-Participating Providers, or the cost of non-Covered Services.

Covered Service or Covered Services: Medically Necessary and preventive services, including supplies and prescription drugs, that Members are entitled to receive from Molina under this Plan, unless otherwise prohibited by federal or State Law.

Deductible: The amount Members pay for Covered Services before Molina begins to pay for Covered Services. To find out which Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan, please refer to the Schedule of Benefits.

Dependent: A Member who meets the eligibility criteria as a Dependent, as outlined in this Agreement.

Distant Site: This is the location where a physician or other licensed Provider, delivering a professional service is physically located when providing the service through telemedicine.

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

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

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

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

With respect to a pregnant woman who is having contractions, an emergency medical condition means that there is adequate time to effect a safe transfer to another hospital

before delivery, or that transfer may pose a threat to the health or safety of the woman or child.

Emergency Services: Services to evaluate, treat or Stabilize an Emergency Medical Condition. These services may be provided in a licensed hospital emergency department, independent freestanding emergency department, or other facility that provides treatment of emergency medical conditions. This includes a medical screening examination undertaken to determine whether an emergency medical condition exists and treatment necessary to Stabilize an emergency medical condition, regardless of the department of the hospital in which such treatment is furnished.

Emergency Transportation Services: Ambulance transfers undertaken before stabilizing an Emergency Medical Condition.

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

FDA: The United States Food and Drug Administration.

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

Marketplace: A governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and assists residents of the State in purchasing 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 required for diagnosing or treating an illness, injury, condition, disease, or its symptoms, and that meet accepted medical standards.

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 such cases, the subscriber will be responsible for making the

Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this Agreement but will not be considered a Member.

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

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

Molina Healthcare of Ohio, Inc. Agreement and Individual Policy: This document, which provides information about coverage under this Plan and is also referred to as the "Agreement."

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

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

Out-of-Area Service: A service 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 is licensed or otherwise authorized to provide health care services. They have entered into network contracts with Molina to provide Covered Services to Members.

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

Post-Stabilization Services: Items and services furnished (regardless of the department of the Hospital where it occurs) after the Member has been stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the visit during which Emergency Services were provided.

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, or Physician Assistant, as allowed under State Law and the terms of the Plan, who provides, coordinates, or assists a Member in accessing 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, institution, organization, pharmacy, or individual that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

Schedule of Benefits: A detailed list of Covered Services, along with the associated Member Cost Sharing.

Service Area: The geographic region where Molina is authorized by the State to offer individual products through the Marketplace, enroll Members seeking coverage via the Marketplace, and deliver 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 specific 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 the State of Ohio encompassing the state's constitution, statutes, regulations, sub-regulatory guidance, directives from state regulatory agencies, and common law.

Subscriber: The individual enrolling in coverage who has elected benefits for themselves and any eligible dependents. There is always only one Subscriber per enrollment group and each Member of the enrollment group will be associated with the Subscriber.

Unanticipated Out-of-Network Care: Health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when the covered person did not have the ability to request such services from an in-network provider.

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

ENROLLMENT AND ELIGIBILITY

To access Covered Services, an individual must be enrolled as a Member of this Plan. Enrollment requires meeting the eligibility criteria set by the Marketplace. Once the eligibility conditions are met, Premiums are paid, and Molina processes the enrollment, the individual becomes a Member of this Plan.

Open Enrollment Period: The Marketplace will establish an annual period during which eligible individuals can apply and enroll in a health insurance plan for the upcoming year. The Effective Date of coverage will be either January 1st, or a date determined by the Marketplace.

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

Child-Only Coverage: Molina offers Child-Only Coverage for individuals under the age of 21, and a parent or legal guardian applies on behalf of the child. A parent or legal guardian must apply for Child-Only Coverage on behalf of the individual under the age of eighteen (18). For more information regarding eligibility and enrollment, please contact the Marketplace.

Dependents: Subscribers enrolling during an Open Enrollment Period or Special Enrollment Period may also apply to enroll eligible individuals as Dependents. Dependents must meet Marketplace-established eligibility requirements and are subject to this Agreement's terms and conditions. Molina does not limit Dependent eligibility based on financial dependency, residency, student status as a student, employment, eligibility for other coverage, or marital status. The following individuals are considered Dependents:

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

- **Child or Children:** The Subscriber's sons, daughters, adopted children, stepchildren, foster children, or any of their descendants, such as grandchildren. Each child is eligible seek enrollment as a Dependent until reaching the age of 26.

- **Child with a Disability:** A child who reaches age 26 can remain a Dependent if they meet the following criteria:
  - The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and

- The child is primarily dependent on the Subscriber for support and maintenance, regardless of age, if the Child is permanently and totally disabled.
- The child remains covered by Molina as long as they remain incapacitated and meet the above eligibility criteria.

- **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's enrollment in this Plan. The eligible individual may be able to enroll as a Dependent in the Member's Plan. To do so, Members must contact the Marketplace and complete any required applications, forms, and provide the requested information for the Dependent. To enroll a new Dependent, a Member's request must be submitted to the Marketplace within 60 days from the date when 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
  - The Spouse gains status as a citizen, national, or lawfully present individual

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

- **Adopted or Newborn Child:** A newborn child of a Subscriber is eligible as a Dependent at birth or the date of adoption placement. A newborn is initially covered for 31 days, including the date of birth. A newborn child is eligible to continue enrollment if they enroll with Molina within 60 days of any birth or adoption placement.

Please note, claims for newborns for eligible Covered Services will be processed as part of the mother's claims. Any Deductible or Annual Out-of-Pocket Maximum (OOPM) amounts met through the processing of a newborn's claims will accrue as part of the mother's Deductible and OOPM. However, if we receive an enrollment file for the newborn within the first 31 days after birth, the newborn will be added as a Dependent

with coverage starting from their date of birth. In this case, any claims for the newborn will be processed separately, and any Deductible or OOPM amounts met through these claims will be considered part of the newborn's individual Deductible or OOPM, not the mother's. A claim is considered a newborn's claim when the services are provided to the newborn child.

- **Court Order or Child Support Order:** If a child becomes a Dependent of the Subscriber or their Spouse through a child support order or other court order, then the child shall be eligible for coverage under this Agreement. A Dependent can be added to this Agreement during the Open Enrollment Period or within 60 days of the effective date of the court order. The child shall be eligible for coverage on the date the court order is effective or as otherwise determined by the Marketplace, in accordance with applicable State and Federal laws.

- **Foster Child:** If a child is placed with the Subscriber or their Spouse for foster care, then the child shall be eligible for coverage under this Agreement. A foster child can be added to this Agreement during the Open Enrollment Period or within 60 days of the child's placement with the Subscriber or their Spouse in foster care. The child's coverage shall be effective on the date of placement in foster care or as otherwise determined by the Marketplace, in accordance with applicable State and Federal laws.

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

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

Continued Eligibility: If a Member becomes ineligible for coverage under this Plan, Molina will send a written notice at least 30 days before the effective date when the Member's coverage will end. The Member has the option to appeal the loss of eligibility with the Marketplace.

Option for Conversion: Subject to eligibility requirements, Members may have the option to convert to the Subscriber under this Agreement under the following circumstances:

1) The Member's spouse dies,

2) The Member's marriage to his or her spouse is terminated by divorce, dissolution, annulment, or other legally recognized manner, or
3) The Member is a child that reaches the limiting age under this Agreement while he or she is still a dependent.

PREMIUM PAYMENT

To begin and maintain coverage under this Plan, Molina requires Members to make monthly payments called Premium Payments or Premiums. Premiums for the upcoming coverage month are due no later than the 25th day of the current month (referred to as the "Due Date"). Molina will send the Subscriber a written notice before the Due Date to let them know how much to pay for next month's coverage.

Advanced Premium Tax Credit (APTC): This is a tax credit that allows the Subscriber to reduce their monthly Premium in advance. Molina does not determine or provide these tax credits. Subscribers should contact the Marketplace to check if they qualify. If eligible, Subscribers can use the tax credit in advance to lower their Premium.

Payment: Molina accepts Premium Payments online, by phone, by mail, and through money order. Please refer to MolinaPayment.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 and indicated below, may not be accepted:

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

Late Payment Notice: Molina will send a written notice to the Subscriber's address of record if full payment of the Premium is not received on or before the Due Date. These notifications 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 before 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: The Grace Period is the time after the Premium Payment due date when the full payment has not been made. If a Subscriber has not paid the Premium Payment in full by the Due Date, they can do so during the Grace Period to avoid losing their coverage. The length of time for the Grace Period depends on whether the Subscriber receives an Advanced Premium Tax Credit (APTC).

- **Grace Period for Subscribers with APTCs:** When a Subscriber receives APTC and misses the Premium Payment due date, Molina provides a three-month consecutive Grace Period. It starts on the first day of the first month on which full

Premium is not paid. During the Grace Period, Molina will process all appropriate claims for Covered Services rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for Covered 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 all past due Premiums are not paid by the end of the third month. Members will be responsible for payment of Covered Services during the second and third months of the Grace Period if this Agreement is terminated.

- **Grace Period for Subscribers without APTC:** When a Subscriber does not receive APTC and misses the Premium Payment due date, Molina provides a consecutive 10-day Grace Period. It starts on the first day of the month for which full Premium is paid. During this time, Molina pays all appropriate claims for Covered Services. Molina will terminate the Agreement as of 11:59 p.m. Eastern on the last day of the Grace Period if all past due Premiums are not paid.

Termination Notification for Nonpayment: Molina will send written notice to the Subscriber, informing them that their coverage, as well as coverage for their Dependents, has been terminated. Members may appeal this termination decision by Molina. For more information on how to file an appeal, please visit MolinaMarketplace.com, check the Appeals and Grievances section of this Agreement, or contact Customer Support.

Reinstatement After Termination: Molina permits the reinstatement of Members, without a gap in coverage if the reinstatement corrects an erroneous termination or cancellation action and is approved by the Marketplace and aligns with State Law.

Re-enrollment After Termination for Nonpayment: If a Subscriber is terminated for nonpayment of Premium and wants to enroll with Molina for the following plan year during the Open Enrollment Period or a Special Enrollment Period, Molina may seek payment of any past due Premiums owed by the Subscriber. Molina will not deny coverage or enrollment to an individual due to the individual's failure to pay premium owed under a prior policy, certificate, or contract of insurance. 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 continue coverage for Members on the first day of each month if all due Premiums have been received. Annual renewal is subject to Molina’s right to make changes to this Agreement and the Member’s ongoing eligibility for this Plan. Members must follow the procedures required by the Marketplace to redetermine eligibility and renewal for enrollment every year during the Open Enrollment Period.

TERMINATION OF COVERAGE

The termination date is the first day a former Member is no longer enrolled with Molina. Coverage for a former Member ends at 11:59 p.m. Eastern on the day before the termination date. Molina will send notice of termination to the Member at least 30 days before the termination date, including the reason for termination. If Molina terminates a Member for any reason, the Member must pay all outstanding amounts related to their coverage with Molina, including Premiums, for the period before the termination date.

Unless there is fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member for periods after the termination date, minus any amounts owed to Molina or its Providers for Covered Services provided before the termination date will be refunded to the Subscriber within 30 days. Molina and its Providers will have no further liability or obligation under this Plan. In cases of fraud or intentional misrepresentation, Molina may retain portions of this amount recover losses due to the fraud.

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

Ineligibility of Dependent and Child-Only Coverage Due to Age: When a Dependent no longer meets the age eligibility requirements for coverage set by both the Marketplace and Molina, termination will occur. For further details on the effective date of termination, please refer to the "Discontinuation of Dependent Coverage" section.

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

Nonpayment of Premium: Please refer to "Premium Payment" section

Fraud or Intentional Misrepresentation: If a Member engages in fraudulent activity or intentionally misrepresents a material fact related to their coverage, Molina will send written notice of recission of coverage, and the Member's coverage will end at 11:59 p.m. Eastern on the 30th day from the date notification is sent. Molina may refuse future enrollment from the Member and may report any suspected criminal acts to authorities. Members have the option to appeal the recission of coverage.

Member Disenrollment Request: Members can request disenrollment through the Marketplace. The Marketplace will determine the Coverage end date.

Discontinuation of a Particular Product: If Molina decides to stop offering a particular product, in accordance with State Law, Molina will provide written notice of discontinuation at least 90 calendar days before the coverage ends.

Discontinuation of All Coverage: If Molina decides to stop offering all health insurance coverage in a State in accordance with State Law, Molina will send Members written notice of discontinuation at least 180 calendar days before the coverage ends.

CONTINUITY OF CARE

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

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

In either case, Members will be timely notified of their right to elect continued care from such Provider under the same terms and conditions that would have applied if the Provider was still a Participating Provider. If the Member elects to continue the care, these terms and conditions will apply for 90 days from Molina's notice or until the Active Course of Treatment ends, whichever is shorter.

An Active Course of Treatment is when the Member:

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

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

Transition of Care: If a Member is hospitalized on the effective date of this Agreement, and their previous health insurance coverage ended before this Agreement began but still covers the hospital stay, Molina will not cover any hospital costs until the Member is either discharged or the prior coverage benefits are exhausted—whichever comes first. Discharge refers to the formal release from the hospital once inpatient care is no longer needed; a transfer between hospitals does not count as a discharge. If the prior insurance no longer covers the hospital stay after it ends, the Continuity of Care section

of this Agreement will apply. If the Member has no prior coverage, or if that coverage does not extend past the effective date of this Agreement, Molina will cover applicable services starting from that date. Members must notify Molina within two days of their effective date so we can review and approve any Medically Necessary services. If care is received at a Non-Participating Hospital, and Balance Billing protections do not apply, the hospital may bill the Member for the difference between Molina's Allowed Amount and the hospital's charges.

ACCESS TO CARE

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

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

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 that is a Hospital, ambulatory surgical center, or other Participating Facility required by State Law, unless the Member waives Balance Billing protections
- Air ambulance services
- Services from a Non-Participating Provider that are subject to Prior Authorization
- Exceptions described under Continuity of Care section

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

Members can find additional information on MolinaMarketplace.com or by contacting Customer Support 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 allows Members to seek healthcare services outside this Agreement on any terms or conditions they choose. However, Members will be fully responsible for payment for such services, and these payments will not count toward their Deductible or Annual Out-

of-Pocket Maximum for services covered under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement and refer to applicable Balance Billing protections provided by Federal and State Law.

Primary Care Provider (PCP): A PCP handles routine and basic healthcare needs. PCPs offer services like physical exams, immunizations, and treatment for non-urgent health issues or injuries. Molina encourages Members to select a PCP from the Provider Directory. If a PCP is not selected, one will be assigned by Molina. Members can request to change their PCP at any time at MyMolina.com or by contacting Customer Support.

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, with no referral required.

Sometimes a Member may not be able to select the PCP from the Provider Directory they want. This may happen because:

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

Telehealth Services: Telehealth involves the use of telecommunications and information technology to provide access to health assessments, diagnoses, interventions, consultations, supervision, and information across geographical distances. Covered Services are 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 (or as detailed in the "Non-Participating Provider to Provide a Covered Service" section below)
- 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
- Molina provides coverage for telehealth services on the same basis and to the same extent that the plan provides coverage for the provision of in-person health care services
- Molina does not exclude coverage for a service solely because it is provided through telehealth
- Molina does not impose any annual or lifetime benefit maximum in relation to telehealth services other than such a benefit maximum imposed on all benefits offered under the plan

For Covered Services provided through store-and-forward (asynchronous) technology, an in-person office visit is required to establish a diagnosis or treatment plan.

Non-Participating Provider to Provide a Covered Service: In the event that no Participating Provider is available to provide a non-Emergency, Medically Necessary

Covered Service, Molina will arrange to provide the Covered Service through a Non-Participating Provider. The Covered Service will be provided in a manner consistent with and at no greater cost than the same Covered Service when delivered by a Participating Provider.

However, Prior Authorization is required before a Non-Participating Provider can initiate the service in this scenario.

Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Non-Participating Providers' Balance Billing (sometimes called "surprise billing") for Emergency Services and other specified items or services. Molina will comply with these state and federal requirements including how we process claims from certain Non-Participating Providers.

Moral Objections: Some Participating Providers may object to providing 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 and requires that Molina and its contractors make reasonable accommodations for Members with disabilities. To request reasonable accommodation assistance, Members with disabilities can contact Customer Support.

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

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

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important product materials will be made available in accessible formats for persons with low vision or who are blind. Large print 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 Appeals and Grievances section of this Agreement for information regarding how to file a grievance.

PRIOR AUTHORIZATION

Molina must approve certain medical services and prescription drugs before covering them. This process is referred to as Prior Authorization ("PA"). Many Covered Services can be received without the need for a PA. If a medical service or drug needs PA, the Member's Provider will seek PA on their behalf.

For a comprehensive list of Covered Services and information about whether they require PA, please visit MolinaMarketplace.com/OHGetCare. The list specifies which services require PA and which do not. Additionally, Members can reach out to Customer Support for assistance.

Molina reviews PA requests upon receiving all required information. In urgent cases, a Member's Provider may request expedited PA processing. Molina will communicate the decision to the Member's Provider within the timeframes allowed by State and Federal Law.

Members will be notified if their PA request is denied, and they will receive information on how to appeal the denial.

Please note that PA rules are subject to change. Members are encouraged to contact Customer Support or visit MolinaMarketplace.com before seeking certain services.

PA Timeframes

Medical Services:

- **Routine PA Requests:**
  - Will be processed within ten (10) calendar days from receipt of all information reasonably necessary and requested by Molina to make the determination.
- **Urgent PA Requests:**
  - Within forty-eight (48) hours from receipt of all reasonably necessary information and requested by Molina to make the determination.
  - The urgent timeframes apply if use of the standard timeframes:
    - 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 Concurrent Review process discussed below.

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

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

The criteria for determining Medical Necessity for healthcare services include evaluating if the services align with the Member's diagnosis or condition concerning type, amount, frequency, level, setting, and duration. The assessment of Medical Necessity is based on generally accepted medical and scientific evidence and consistent with generally accepted practice parameters.

Molina will not grant Prior Authorization if the necessary information for review is not provided. Services that do not meet the criteria for Medical Necessity will not receive approval. If the service requested is not a Covered Service, it will not be approved. Members receive written notice explaining the reasons for the denial of the Prior Authorization. The Member, Member's Authorized Representative, or their Provider, with the Member's consent, can appeal the decision for Medical Necessity determination. The decision letter will inform Members of the process to appeal the denial decision. These instructions are also in the section of this Agreement titled Claims Decisions, Complaints Internal and External Appeals.

If a Member or their Provider chooses to proceed with a service that has not been authorized by Molina, the Member will be responsible for covering the cost of those services.

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

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.

Referral: A Member's PCP may send them to another Provider for a specific Covered Service. This process is a referral. A referral is not required to visit another Participating Provider.

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

COORDINATION OF BENEFITS (COB)

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

Definitions:

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

(1) Plan includes: group and nongroup insurance contracts, Health Maintenance Organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When

this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

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

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

   (1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
   (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
   (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
   (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
   (5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

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

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits 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; (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan; or (iii) However, if one spouse's plan has

some other coordination rule (for example, a “gender rule” which says the father’s plan is always primary), we will follow the rules of that 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 not 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.

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

Coordination Disputes: If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Member Services at (888) 296-7677 or MolinaMarketplace.com. Please also refer to the “Claims Decisions, Complaints, Internal and External Appeal” section of this Agreement for more information. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at http://insurance.ohio.gov.

COST SHARING

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

Members receiving covered inpatient Hospital or skilled nursing facility services on the effective date of this Agreement pay the Cost Sharing in effect for this Agreement upon the effective date of coverage with Molina. For items ordered in advance, Members pay the Cost Sharing in effect for this Agreement upon the effective date, for Covered Services only. 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 approved by Molina if Prior Authorization is required;
- 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.

Molina will not cover any services, supplies, or equipment that are either provided prior to the effective date or after the termination date of this Agreement. Members should read this Agreement completely and carefully 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. on the last day of the month that they turn age 19. This includes pediatric dental coverage and pediatric vision coverage. Pediatric dental services are not covered under this Agreement. These dental services can be purchased separately through a stand-alone dental product that is certified by the Marketplace.

EHBs include items and services in the following 10 benefit categories: (1) ambulatory patient services; (2) Emergency Services; (3) hospitalization; (4) maternity and newborn care; (5) Mental Health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitation and habilitation services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

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 Sharing.

- Molina must ensure that the Cost Sharing that Members pay for all EHBs does not exceed an annual limit 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.

Molina will apply all Cost Sharing (including Balance Billing) paid by a Member for an EHB provided by an ancillary Non-Participating Provider in a Participating Provider facility to the Annual Out-of-Pocket Maximum. Molina will provide to the Member written notice in advance if the Member will incur additional costs because a Non-Participating Provider was used in a Participating Provider facility. The Non-Participating Provider will be paid Molina's Allowed Amount for the Covered Services.

Basic Health Care Services: According to Chapter 1751.01 of the Ohio Revised Code, the following Covered Services are considered Basic Health Care Services when Medically Necessary:

- Physician's services;
- Inpatient hospital services;
- Outpatient medical services;
- Emergency health services;
- Urgent care services;
- Diagnostic laboratory services and diagnostic and therapeutic radiologic services;
- Diagnostic and treatment services for mental health disorders, other than prescription drug services;
- Preventive health services, including, but not limited to: voluntary family planning services, infertility services, periodic physical examinations, pre-natal obstetrical care, and well-child care; and
- Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

Basic Health Care Services does not include Experimental or Investigational procedures.

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

Approved Clinical Trials: Molina covers routine patient care costs for qualifying Members participating in Approved Clinical Trials for cancer and/or another life-threatening disease or condition. A Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of

the disease or condition is interrupted. Members will never be enrolled in a clinical trial without their consent.

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

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

All approvals and Prior Authorization requirements that apply to routine care for Members not in an Approved Clinical Trial also apply to routine care for Members in Approved Clinical Trials. If a Member qualifies, Molina cannot deny their participation. Additionally, 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 an Approved 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:

1. the investigational item, device or service itself,
2. items and services solely for data collection and analysis purposes and not for direct clinical management of the patient,
3. any service inconsistent with the established standard of care for the patient's diagnosis, and
4. transportation, lodging, food, and other expenses associated with the travel to or from a Facility providing the Approved Clinical Trial.

Services or routine patient costs associated with Approved Clinical Trials obtained from a Non-Participating Provider are not covered.

If one or more Participating Providers are taking part in an Approved Clinical Trial, Molina may require that a Member participate in the trial through such Participating Provider as long as the Provider accepts the Member as a participant in the Approved Clinical Trial.

If the Approved Clinical Trial is being conducted outside the Member's state of residence, coverage for routine patient services related to the Approved Clinical Trial will not be denied solely because the trial is conducted out-of-state.

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 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 regarding coverage.

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 screen, 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), four post-mastectomy surgical bras, 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)
- One wig per year following cancer treatment

Complex Case Management: Members with difficult health problems that need extra help with the coordination of their healthcare needs, including opioid treatment may voluntarily enroll in Molina Case Management program. This program allows Members to talk with a nurse about their healthcare needs. The nurse can help Members learn about their problems and teach them how to better manage them. The nurse may also work with a Member's family, caregiver, and Provider to make sure they get the care they need. There are several ways Members can be referred for this program. There are also certain requirements that Members must meet. This program is voluntary. Members can choose to be removed from the program at any time. For more information about this program, please contact Customer Support.

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

- Dental services for radiation treatment
- Dental anesthesia, if all of the following apply:
    - The Member is under the age of 7, are developmentally disabled, or the Member's health is compromised
    - The Member's clinical status or underlying medical condition requires that the dental procedure be provided in a Hospital or outpatient surgery center
    - The dental procedure would not ordinarily require general anesthesia
- Dental and Orthodontic services that are an integral part of a reconstructive surgery for cleft palate
- Dental services that are integral to transplant preparation, initiation of immunosuppressives, and direct treatment of acute head and neck traumatic injury, head and neck cancers, or 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 (limited to $ 3,000 per accident)
    - Services must be within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.
    - For a child requiring facial reconstruction due to dental related injury, there may be several years between the and the final repair
- Facility charges for outpatient services. Benefits are payable for the removal of teeth or for other dental processes only if the Member's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the Member

IMPORTANT: If you opt to receive dental care services that are not covered benefits under this plan, a participating dental care provider may charge you his or her normal fee for such services. Prior to providing you with dental care services that are not covered benefits, the dental care provider will provide you with an estimated cost for each service.

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 education and self-management
    - Diabetes (Type 2) screening
    - Screening for gestational diabetes
- Dietician services
- Nutritional counseling

For information regarding diabetes supplies, please refer to the Prescription Drug section of this Agreement.

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 Member satisfies all medical criteria developed by Molina.

Molina covers both inpatient and outpatient kidney dialysis.

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

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

Emergency Services Rendered by a Non-Participating Provider: Molina covers Emergency Services obtained from Non-Participating Providers in accordance with State and Federal Law. Emergency Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in

the Schedule of Benefits at the in-network level. Members are not subject to Balance Billing for Emergency Services.

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

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

Emergency Transportation Services: Emergency Transportation Services (air and ground) are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. Covered Emergency Transportation Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing identified in the Schedule of Benefits at the in-network level.

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, education, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain or remove a contraceptive.

Molina will defer to the determination of the Member's attending Provider's determination of Medical Necessity. Molina does not cover condoms for males, as excluded under the ACA.

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.

Habilitation Services include:

- Treatment of Autism Spectrum Disorder for children ages 0-21
- Outpatient physical habilitation services including:
  - Speech and language therapy performed by a licensed therapist: 20 visits per year;
  - Occupational therapy performed by a licensed therapist: 20 visits per year; and
  - Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the State of Ohio to perform the services in accordance with a treatment plan: 20 hours per week.
- Outpatient mental health services performed by a licensed psychologist, psychiatrist, or physician to provide consultation, assessment, development, and oversight of treatment plans.

Hearing Aids and Related Services: Molina provides coverage for medically appropriate hearing aids and related services for members who are 21 years old or younger. These services require Prior Authorization and are limited to the following:

- Hearing Aids: Coverage includes one hearing aid per ear for those with hearing impairment, up to $2,500 every 48 months without Cost Sharing. A licensed audiologist, otolaryngologist, or another licensed physician must verify the Member's hearing impairment. If a Member chooses a hearing aid that costs more than $2,500, they will need to pay the difference.
- Related Services: Services related to hearing aids, such as those prescribed by an otolaryngologist (a licensed physician specializing in ear, nose, and throat care) or recommended by a licensed audiologist, will be covered without Cost Sharing. These services must be dispensed by a licensed audiologist, hearing aid dealer, or fitter, or an otolaryngologist.

As used in this provision, a “Hearing Aid” is device designed to help or compensate for impaired hearing. This includes all parts, attachments, and accessories, excluding batteries and cords. The device must be dispensed by a licensed audiologist, hearing aid dealer, fitter, or otolaryngologist. Hearing Aids must be deemed medically appropriate to meet the needs of the Member based on professional standards set by the Ohio Speech and Hearing Professionals Board.

“Related Services” are medically appropriate services needed to assess, select, and appropriately adjust or fit a hearing aid to ensure optimal performance

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
- Medically Necessary medical appliances
- Nurse visits and part-time skilled nursing services
- Physical, occupational, speech or respiratory therapy
- Part-time skilled nursing services
- Cardiac and Pulmonary rehabilitation (Pulmonary rehabilitation in the acute inpatient rehabilitation setting is not a Covered Service)

The following home healthcare services are covered:

- Up to 2 hours per visit by a nurse, medical social worker, physical, occupational, or speech therapist
- Up to 4 hours per visit by a home health aide
- Up to 100 visits per calendar year (counting all home health visits, except private duty nursing visits)

Molina also covers private duty nursing if such services are certified by the Member’s PCP initially and every two weeks thereafter, or more frequently if required by Molina for Medical Necessity review. There is a limit of 90 visits per calendar year for such private duty nursing services in the home. Members must have Prior Authorization for home healthcare services after the first 6 visits for outpatient and home settings. Services must be billed by a Home Healthcare Participating Provider agency.

Home Infusion Therapy: Molina covers home infusion therapy include a combination of nursing, durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to, injections (intra-muscular, subcutaneous, and continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.

Hospice Services: Molina covers hospice services for Members who are terminally ill (a life expectancy of 6 months or less). Covered Services will continue if the Member lives longer than six months. 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 for up to 7 days per occurrence.

Infertility Services: Molina covers diagnostic and exploratory procedures to determine infertility. These include surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including, but not limited to, endometriosis, collapsed/clogged fallopian tubes, or testicular failure.

Inpatient Hospital Services: Members must have a Prior Authorization before receiving covered hospital services, except in the case of Emergency and other exceptions identified in this Agreement. Post-Stabilization Services received in a Non-Participating Provider Hospital after admission to the Hospital for Emergency Services, will be covered provided the services are authorized, the Member's coverage with Molina has not terminated, and the Member has not waived Balance Billing protections pursuant to federal or State 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 Member's inpatient Hospital stay, Molina will continue coverage until the earliest occurrence of any of the following:

- The Member's discharge from the hospital;
- The determination by the Member's attending physician that inpatient care is no longer medically indicated for the enrollee. Molina may still conduct utilization review;
- The Member's reaching the limit for Agreement benefits;
- The effective date of any new coverage

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

Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services: 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 also covers Mental Health Services for Emergency Services and Post Stabilization Services when provided by Participating and Non-Participating Providers. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria to the extent

required by federal and state law. Molina may require Prior Authorization for coverage of services, including admissions and certain outpatient services. The concurrent review authorization process applies to all involuntary admissions. See the “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

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
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Covered Dependents have direct access to obstetrical and gynecological care.
- Sleep studies (Separate facility Cost Sharing may apply)

Pregnancy and Maternity: For prenatal care, Members may choose any Molina Participating Provider who is either an obstetrician/gynecologist (OB/GYN), certified nurse midwife, or nurse practitioner who is trained in women's health. The coverage shall apply to services provided in a medical setting or through home healthcare visits. The coverage shall apply to a home healthcare visit only if the Provider who conducts the visit is knowledgeable and experienced in maternity and newborn care. Outpatient maternity and newborn care includes:

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia
- Related 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.
- Routine nursery care for newborns

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

Molina also covers Provider directed follow-up care including:

- Physical assessment of the mother and newborn
- Parent education
- Assistance and training in breast or bottle feeding
- Assessment of the home support system
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals

Pregnancy Termination: Molina covers pregnancy termination services only to the extent required by the Affordable Care Act, federal law, and by any State Law. A therapeutic pregnancy termination is performed to save the life or health of the mother, or as a result of incest or rape.

Pregnancy termination services that are provided in an inpatient or outpatient Hospital setting require Prior Authorization. Pregnancy termination services, when performed in the office, do not require Prior Authorization.

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

- Those evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). Please visit the USPSTF website for preventive services recommendations at: uspreventiveservicestaskforce.org;
- Tobacco use screening for all adults and cessation interventions for tobacco users. Please refer to the "Prescription Drugs to Stop Smoking" section of this Agreement for more information;
- 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). These services include well baby visits and care; and
- With respect to women, those preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF. Please visit the HRSA website for preventive services recommendations at: hrsa.gov/womens-guidelines. These services include, but are not limited to:
    - Breast exams and screening mammography, including digital breast tomosynthesis, once per year for women regardless of age or risk factors.
    - Supplemental breast cancer screening when dense breast tissue is detected, or increased risk factors are present. Supplemental breast cancer includes magnetic resonance imaging (MRI), ultrasound, and molecular breast imaging or any another method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American College of Radiology Guidelines.
    - Cytological Screening (pap smear) for women every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology.
    - Pap smear for women based on their age and health status including human papilloma virus.
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection without cost-sharing. This includes:
    - PrEP medication (antiviral drugs when prescribed to prevent HIV infection)
    - Laboratory tests and other diagnostic procedures (including testing for HIV, sexually transmitted infections, renal functionality, Hepatitis B, Hepatitis C, and lipid panel)
    - Counseling about antiretroviral medication adherence

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. Office visits associated with preventive services are covered at no Cost Sharing when the service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, and the primary purpose of the office visit is the delivery of the recommended preventive service.

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

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

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

Internally implanted devices:

- Cochlear implants
- Hip joints
- Intraocular lenses (including contact lenses or glasses following implantation and the first pair of contact lenses or glasses which replace the function of the human lens for conditions caused by cataract surgery or injury. A donor lens is not the first lens)
- Osseointegrated hearing devices
- Pacemakers

External devices:

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

Coverage is dependent on all the following requirements being met:

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

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

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

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 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. Rehabilitation Services include:

- Physical therapy (20 visit limit per calendar year)
- Speech therapy (20 visit limit per calendar year)
- Occupational therapy (20 visit limit per calendar year)
- Manipulation therapy (12 visit limit per calendar year)
- Cardiac rehabilitation (36 visit limit per calendar year)
- Pulmonary rehabilitation (20 visit limit per calendar year)

Rehabilitation services may be subject to limitations, Prior Authorization requirements, and exclusions. Please contact Customer Support for additional coverage information.

Routine Adult Dental Services (age 19 and older): The following routine adult dental services are Covered Services for Members age 19 and older when provided by a Participating Provider.

Molina covers the following diagnostic services, preventive services, and special consultations when Medically Necessary:

- Diagnostic services including procedures to aid the Participating Provider in determining required dental treatment.
- Preventive services including cleanings, scaling in presence of generalized moderate or severe gingival inflammation - full mouth (please note: periodontal maintenance is considered to be a basic service for Cost Sharing purposes).
- Specialist consultation opinion or advice requested by a general dentist.

Molina covers the following basic dental services when Medically Necessary:

- General anesthesia or IV sedation when administered by a Participating Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- Periodontal cleanings for periodontal maintenance.
- Palliative emergency treatment to relieve pain.
- Restorative services including amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

Molina covers the following major dental services when Medically Necessary:

- Crowns and inlays/onlays, including treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- Prosthodontics procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and implant supported prosthetics, including implant repair and recementation.
- Oral surgery for extractions and certain other surgical procedures (including pre- and post-operative care).
- Endodontics for the treatment of diseases and injuries of the tooth pulp.
- Periodontics for the treatment of gums and bones supporting teeth.
- Denture repair to partial or complete dentures, including rebase procedures and relining.

Note on additional Covered Services during pregnancy: When a Member is pregnant, Molina will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services that are available each Calendar Year while the Member is covered under the Policy include:

- One (1) additional oral exam, and either:
    - One (1) additional routine cleaning;
    - One (1) additional periodontal scaling and root planing per quadrant; or
    - One (1) additional periodontal maintenance procedure.

Written confirmation of the pregnancy must be provided by the Member or the Member's Provider when the claim is submitted.

Exclusions and Limitations: Certain dental services are excluded or have limited coverage under all Molina plans, including those with coverage for routine adult dental services. These exclusions and limitations apply regardless of whether the services are within the scope of a Provider's license. Specific dental services have limited coverage under this plan and are outlined below:

- *"Optional Services"* - Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards . Optional Services also include the use of specialized techniques instead of standard procedures.
  Examples of Optional Services:
  - A composite restoration instead of an amalgam restoration on posterior teeth;
  - A crown where a filling would restore the tooth;
  - An inlay/onlay instead of an amalgam restoration; or
  - Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

  If a Member receives Optional Services, an alternate Benefit will be allowed, which means Molina will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service.The Member will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.
- If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Agreement. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- Molina will pay for oral examinations (except after hours exams and exams for observation) no more than one (1) every six (6) months in a calendar year.
- Molina will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than one (1) every six (6) months in a calendar year. A full mouth debridement is allowed once in a lifetime, when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three (3) years, and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, procedure codes that include periodontal maintenance, and full mouth debridement are covered as a basic benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive benefit. See note on additional Covered Services during pregnancy.
- A caries risk assessment is allowed once in 12 months.

- Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
- Application of caries arresting medicament is covered once per tooth every six (6) months when the Member has a caries risk assessment and documentation with a finding of high risk.
- Image limitations, including:
    - Molina will limit the total reimbursable amount to the Allowed Amount for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the accepted fee for a comprehensive intraoral series.
    - Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
    - If a panoramic image is taken in conjunction with an intraoral comprehensive intraoral series, Molina will limit reimbursement to the Allowed Amount for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the Member.
    - Panoramic images are not considered part of a comprehensive intraoral series.
    - Bitewing images are limited to one (1) time each calendar year. Bitewings of any type are not billable to the Member or Molina within six (6) months of a full mouth series unless warranted by special circumstances.
    - Bitewing images of any type are included in the fee of a comprehensive series when taken within six (6) months of the comprehensive images.
    - Image capture procedures are not separately billable services.
- Cone beam image limitations, include:
    - Cone beam capture and interpretation is covered once in a 12-month period.
    - Interpretation of a diagnostic image only is covered for cone beam services.
    - This service is covered no more than once in a 12-month period.
    - Cone beam interpretation is a covered benefit when provided by a different dentist/dental office than the dentist/dental office who provided the cone beam capture only services.
- Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- Specialist consultations are limited to once per lifetime per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one (1) in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- Molina will not cover the replacement of amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.

- Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- Pulpal debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.
- Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete endodontic therapy; inoperable, unrestorable or fractured tooth, are limited to once in a lifetime.
- Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Pin retention is covered once in any 24-month period.
- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.
- Periodontal limitations inlude:
    - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two (2) quadrants of scaling and root planing will be covered on the same date of service. See note on additional Covered Services during pregnancy.
    - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
    - Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
    - Guided tissue regeneration and/or bone grafts are not covered in conjunction with soft tissue grafts in the same surgical area.
    - Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
    - Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.
    - When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure, they are covered as a basic benefit and limited to once in a 24-month period.
- Oral Surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.

- General anesthesia, intravenous moderate (conscious) sedation is covered only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.
- Crowns and inlays/onlays are covered once in any 60-month period except when Molina determines the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Core buildup, including any pins, is covered once in any 60-month period.
- Post and core services are covered once in any 60-month period.
- Crown and inlay/onlay repairs are covered once in any 60-month period. crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- The benefit for a crown, inlay/onlay or fixed prosthodontic service, when allowed within six (6) months of a restoration, will be reduced by the benefit paid for the restoration.
- Denture repairs are covered once in any six (6) month period except for fixed denture repairs, which are covered once in any 60-month period.
- Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Molina plan will be replaced only after 60 months have passed, except when Molina determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Molina program will be made if Molina determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Molina or payment for implant removal is limited to one (1) for each implant in 60 months whether provided under Molina or any other dental care plan. Implant/abutment supported removable dentures and fixed dentures will receive a benefit allowance for the corresponding conventional removable appliances. The Member is responsible for the difference in the fee for an implant/abutment supported denture and the fee for a conventional prosthodontic appliance.
- Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments, are covered once in 36 months.
- The fee for accessing and retorquing loose implant screws is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis.
- Debridement of a peri-implant defect or defects surrounding a single implant (with or without osseous contouring), and surface cleaning of the exposed implant surfaces, including flap entry and closure, are covered once in 36 months.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be covered.

- Recementation of crowns, inlays/onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- The initial installation of a prosthodontic appliance and/or implants is not covered unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Member was under a Molina plan.
- Occlusal adjustment is allowed once in a 60-month period.
- Molina will limit payment for dentures to a standard partial or complete denture (Member Cost Sharing applies). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
    - Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
    - Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period.
    - Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.
    - Recementation of fixed partial dentures is limited to once in a lifetime.
- Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a diastema.
- The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

Specific dental services are excluded from coverage under this adult routine dental services benefit and are outlined below:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.

- Maxillofacial prosthetics.
- Provisional and/or temporary restorations.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.
- Any single procedure provided prior to the date the Member became eligible for services under this plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- Interim implants.
- Indirectly fabricated resin-based inlays/onlays.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- Treatment by someone other than a Participant Provider or a person who by law may work under a Provider's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the policy, will be the responsibility of the Member and not a covered benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under the dental benefit.

- Services covered under the dental benefit but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- The initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one (1) or more natural, permanent teeth extracted while the Member is covered under the Agreement or was covered under any dental care plan with Molina.The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric images, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.
- Services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- Endodontic endosseous implants.
- Services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- Cone beam image capture only.
- Diabetes testing.
- Corticotomy (specialized oral surgery procedure associated with orthodontics).
- Antigen or antibody testing.
- Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.
- Services or supplies for sleep apnea.

Skilled Nursing Facility: Molina covers 90 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 Prior Authorization for coverage of services, including inpatient and certain outpatient services. Molina also provides coverage for substance use disorder treatment in a nonmedical transitional residential recovery setting when Prior Authorized. Molina covers the following outpatient care for treatment of substance use disorder:

- 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)

Substance Use Disorder Covered Services include opioid treatment. Molina will process Prior Authorization request for opioid treatment as an expedited request. Molina will also consider the urgency of the Member's situation when making decisions about any Adverse Benefit Determination related to the treatment of opioid abuse.

Outpatient care for treatment of substance use disorder does not include therapy or counseling for any of the following: career, marriage, divorce, parental, job, 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 Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost Sharing.

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

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

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 provides donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. Donor benefits are limited to benefits not available to the donor from any other source. These services must be directly related to a covered transplant for a Member. Included are services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Complications from the donor procedure are covered for up to 6 weeks from the date of procurement.

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

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

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

- Comprehensive vision exam limited to 1 every calendar year
- Prescription glasses which are limited to 1 pair every calendar year (subject to a limited selection of frames) with glass, plastic, or polycarbonate lenses; available in single vision, conventional bifocal, conventional trifocal, and lenticular lenses in all lens powers. Anti-reflective coatings, progressive lenses, photochromatic glass lenses, and hi-index lenses also available.
- Contact lenses which are limited to 1 pair of standard contact lenses every calendar year instead of prescription glasses.
- Medically Necessary contact lenses for specified medical conditions.

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

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

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.

Laser corrective surgery is not covered.

IMPORTANT: If a Member opts to receive vision care services or vision care materials that are not covered benefits under this Plan, a Participating Provider may charge you his or her normal fee for such services or materials. Prior to providing a Member with vision care services or vision care materials that are not covered benefits, the Participating Provider will provide the Member with an estimated cost for each service or material upon request.

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 Molina's 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. Molina will notify the Provider if the request is approved or denied based upon Medical Necessity review.

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

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

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

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

advanced approval for drugs they buy and treat Members with. Some injectable drugs can be approved to get from a pharmacy using the Plan pharmacy benefit.

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

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

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

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

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

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

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

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

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

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

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

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

Drug Tier	Description
Preventive Drugs	Nationally recognized preventive service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 Cost Sharing; additional drugs with $0 Cost Sharing where applicable.
Preferred Generic Drugs	Preferred generic drugs; lowest Cost Sharing.
Preferred Brand Drugs	Preferred brand-name drugs; higher Cost Sharing than preferred generic drugs.
Non-Preferred Drugs	Non-preferred brand-name and generic drugs; higher Cost Sharing than preferred brand-name and generic drugs used to treat the same conditions.
Specialty Drugs	Specialty drugs (brand-name and generic); Drugs that require special handling, complex counseling or monitoring, limited distribution, or other special pharmacy requirements. Higher Cost Sharing than lower tier drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use the 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 Non-Preferred Drugs Tier Cost Share for non-specialty products or the Brand and Generic Specialty Drugs Tier Cost Sharing for Specialty products. These amounts will count towards the Member’s Deductible and Annual Out-of-Pocket Maximum (OOPM). Please note, for nonformulary brand-name products that have a generic product listed on the formulary, if coverage is approved on exception, a Member’s share of the cost will also include the difference in cost between the formulary generic drug and the brand-name drug.

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 https://www.molinamarketplace.com/marketplace/oh/en-us/Providers/Drug-List.

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

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

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

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

Prescription Drugs to Stop Smoking: Molina covers drugs to help Members stop smoking, with no Cost Sharing. This includes tobacco cessation medications and over-the-counter nicotine replacement with a prescription. Members should consult their Provider to determine which drug is right for them. These covered drugs are listed on the Formulary. Specifically, Molina will provide coverage for all FDA-approved tobacco cessation services recommended by the United States Preventive Services Task Force, including individual, group, and telephone counseling, and any combination thereof. For

services associated with more than two attempts to quit within a 12-month period, or treatment exceeding the duration recommended by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use, Prior Authorization may be required.

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 our network of pharmacies, 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. Requests for uses outside of a drug’s FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on usage outside of FDA labeling. Drugs that Providers treat Members with will be subject to Cost Sharing specified for chemotherapy under the medical benefit for the site where treatment is given. Drugs that Members get from pharmacies will be subject to Cost Sharing specified for the pharmacy benefit. Please refer to the Schedule of Benefits for applicable Cost Sharing. Most new anti-cancer drugs are considered 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.

All orally administered cancer medications will be covered on the same basis and at no greater Cost Sharing than imposed for intravenous or injected cancer medication. Provider

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

Extended Day Supply Availability of Formulary Drugs: Molina offers Members an option to fill up to a 90-day supply at network retail pharmacies or a mail order option for certain drugs in the Preventive Drugs, Preferred Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand and Generic Drugs Tiers. Eligible drugs are marked "MAIL" on the Formulary. 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 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.

Pharmacy Benefits Practices: Molina will not directly or indirectly restrict informing Members about less expensive ways to purchase prescription drugs, Molina will not require a Cost Share that is greater than the amount a Member would pay for the drug if it were purchased without coverage.

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

- Drugs not FDA approved or licensed for use in the United States
- Over-the-counter drugs not on the Formulary
- Proposed less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Gene therapy
- Experimental and Investigational drugs (except permitted uses described in the Off-Label Drugs section of this Agreement)
- Weight loss drugs, or diabetic drugs when used off-label to lose weight instead of treating diabetes
- Any drugs that would be illegal to prescribe under federal or State Law, regardless of the state in which the drug is prescribed or filled

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

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

EXCLUSIONS

Certain equipment and services are excluded from coverage under this Agreement. This is not an exhaustive list of services that are excluded from coverage under this Plan. Please note: Medically Necessary variations of the exclusions listed in this section will be covered by Molina. Please contact Molina Customer Support for questions regarding exclusions. Molina does not cover any services that are not identified and included in the Covered Services section of this Agreement. The Member will be fully responsible for payment for any services that are not covered.

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.

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.

This exclusion does not apply to preventive services or services a Participating Provider determines are Medically Necessary.

Chiropractic Services: Chiropractic services are not covered, except when provided in connection as manipulative therapy outlined in the Habilitation and Rehabilitation Services section of this Agreement. Manipulation Therapy includes both osteopathic and chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. Chiropractic therapy focuses on the joints of the spine and the nervous system. Osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

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.

Court Ordered Non-Medically Necessary Care: Services that are court ordered but not Medically Necessary, unless required by State Law.

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

Dietician: A service of a Dietitian is not a Covered Service except for Covered Services under the Hospice Services section.

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.

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.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy (including stem cell therapy), and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization

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

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

Certain Infertility Services: Molina does not cover certain 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). However, Molina does cover diagnostic and exploratory procedures to determine infertility. See the “Infertility Services” section above for additional information.

Incarceration: Molina will not cover services for members when rendered while the member is incarcerated, unless a court order specifically requires coverage

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

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

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

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

Massage Therapy: Massage therapy is not covered.

Medical Tourism: Molina will not cover any expenses related to medical tourism. Medical tourism refers to traveling outside the United States to receive medical care. This includes, but is not limited to, elective procedures, surgeries, treatments, and any follow-up care related to services received outside the country. Members who choose to seek medical care outside the United States will be fully responsible for all costs incurred.

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

Primary Payor Services: Any services where other coverage is primary to Molina must be first paid by the primary payor before coverage under this Agreement can be considered. Please refer to the Coordination of Benefits section for additional information.

Provider-to-Provider Consultation: Molina does not cover interprofessional consultations between providers without the member present.

Provider Incurred Costs: Molina will not cover any expenses, fees, taxes, or surcharges imposed on the Member by any Provider or Facility that are the Provider or Facility's responsibility to pay.

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.

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

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

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

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

Services Provided Outside the Service Area: Except as otherwise provided in this Agreement, any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Customer Support for more information.

Services Provided Outside the United States: Except as otherwise provided in this Agreement, any services (both emergency and non-emergency), supplies, or prescription drugs received outside the United States are not covered.

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

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

Services Rendered by Immediate Family: Any service rendered by an immediate family member of the Member's family.

Services with No Member Incurred Cost: Any service, supplies, or equipment that would be provided without cost to the Member in the absence of Molina covering the charge.

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

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

Travel and Lodging Expenses: Travel and lodging expenses are not covered. Molina may pay certain expenses that Molina preauthorizes in accordance with Molina's travel and lodging guidelines. Molina's travel and lodging guidelines are available from Customer Support. This exclusion does not apply to travel and lodging services associated with covered transplant services outlined in this Agreement.

CLAIMS

Filing a Claim: Providers must promptly submit to Molina claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Molina and must include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Member or Provider to Molina within 365 calendar days after the following have occurred:

- Discharge for inpatient services or the date of service for outpatient services; and
- Provider has been furnished with the correct name and address for Molina.

If Molina is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to Molina within 30 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. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, Molina will pay the Provider of service within 30 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements. The receipt date of a claim is the date Molina receives either written or electronic notice of the claim.

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

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

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

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

- The Member asks for and receives 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 and Subrogation: If a Member suffers an illness, injury, or condition for which any third party is alleged to be liable or responsible, the Member must promptly notify Molina in writing.

If Molina pays a claim for a Member, Molina has immediate subrogation rights and the right to recover from any liable or responsible third party any benefits paid related to the Member's injury, illness, or condition. Member assigns to Molina their right to take legal action against any responsible third party. Member agrees to provide Molina with any relevant information upon request and to participate in any phase of legal action, such as discovery, depositions, and trial testimony.

If the Member does not cooperate with Molina or if the Member does anything that interferes with Molina's rights, Molina may take legal action against the Member. Member also agree not to assign their right to take legal action to someone else without Molina's written consent.

If the illness, injury, or condition that led to subrogation involves a minor child, then the child's guardian or parents are responsible for cooperating with the subrogation and reimbursement process. If the illness, injury, or condition ends in the wrongful death of a member or dependent, then the obligation to cooperate passes to the member or dependent's personal representative.

If a Member recover less than the full value of damages, then Molina's claim shall be diminished in the same proportion as the Member's interest is diminished.

A third party includes, but is not limited to, an individual person; a business entity or organization, a government agency or program; and an insurance company.

Molina's Right of Reimbursement: Molina has the right to be reimbursed if a liable or responsible third party pays a Member directly. If a Member receives any services under the Plan for an illness, injury, or condition alleged to be caused by or caused by a third party and subsequently receive any amount as a judgment, settlement, or other payment from any third party, Molina is entitled to a first-priority right of reimbursement of the amounts paid or to be paid on the Member's behalf for the services related to the illness, injury, or condition for which any third party is alleged to be liable or responsible.

Molina's Rights Take Priority: Molina's rights of subrogation and reimbursement have priority over other claims and will not be affected by any equitable doctrine. The proceeds of any judgment or settlement obtained by a Member or Molina from any liable or responsible third party on account of a Member's injury, illness, or condition shall first be applied to satisfy Molina's subrogation and reimbursement rights. Molina is entitled to recover the amounts paid even if they are not or have not been compensated by the liable or responsible third party for all costs related to the Member's illness, injury, or condition.

Molina is not obligated to pursue reimbursement or take legal action against a third party, either for Molina's own benefit or on a Member's behalf. Molina's rights will not be affected if Molina does not participate in any legal action a Member takes related to their injury, illness, or condition.

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

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 the provision of Covered Services on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex, HIV/AIDS related condition, or genetic information.

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

Agreement Binding on Members: By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal

representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Assignment: A Member may not assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder without Molina's prior written consent. Consent may be refused at Molina's discretion.

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

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

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

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

Time Limit on Certain Defenses: After 2 years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability (as defined in the Agreement) commencing after the expiration of such 2-year period. No claim for loss incurred or disability (as defined in the Certificate) 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.

Wellness and Other Program Benefits: This Agreement includes access to a wellness program offered to encourage Members to complete health activities that support their overall health. The program is voluntary and available to all Subscribers at no cost. The program is additionally available to Dependents 18 years and older at no cost. Molina may offer you rewards or other benefits for participating in certain health activities and programs provided by Participating Providers. 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.

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

Incarcerated Insured: Molina will not exclude or limit coverage because the Member is incarcerated except as permitted by State Law.

Availability of Medicaid: Molina will not exclude coverage because a Member's eligibility for Medicaid.

Availability of Medicare: Molina will not exclude coverage because a Member's eligibility for eligibility for Medicare.

Health Education Materials: Molina offers easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, Opioid education and other topics. To get these materials, Members should ask their Provider or visit our website at: MolinaMarketplace.com/MPHealthEducation

Physical Examination and Autopsy: Molina at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Alcohol or Drug Related Injury: Molina does not exclude or limit coverage for injuries caused by the use of alcohol or drugs.

Cancellation by the Member: The Member may cancel this Agreement at any time by written notice delivered or mailed to Molina, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, Molina will return promptly the unearned portion of any premium paid. The earned premium shall be computed using the short-rate table last filed with the State of Ohio. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. This provision nullifies any other provision, contained in this Agreement or in any indorsement hereon or in any rider attached hereto, which provides for cancellation of this policy by the insurer or by the Member.

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act: Pursuant to Ohio law, the Ohio Life and Health Insurance Guaranty Association (OLHIGA) may provide coverage of claims

under certain life insurance policies, health insurance policies, including sickness and accident and health insuring corporation agreements, annuity contracts, and supplemental contracts to any of the preceding, if the member insurer or health insuring corporation becomes impaired or insolvent.

OLHIGA may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by OLHIGA in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy or health insuring corporation coverage.

Information about the financial condition of insurers can be accessed by visiting the Department's website. For additional information or if you have concerns about a violation of Ohio insurance law or would like to file a complaint, please contact:

Ohio Department of Insurance
50 W. Town Street, Suite 300
Columbus, Ohio 43215
1-800-686-1526
www.insurance.ohio.gov

If you have questions about the obligations of OLHIGA, you may contact:

Ohio Life and Health Insurance Guaranty Association
485 Metro Place South, Suite 270
Dublin, Ohio 43017
614-442-6601
www.olhiga.org

Balance Billing: Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Non-Participating Providers' Balance Billing (sometimes called "surprise billing") for Emergency Services and other specified items or services. Molina will comply with these state and federal requirements including how we process claims from certain Non-Participating Providers.

CLAIMS DECISIONS, COMPLAINTS, INTERNAL AND EXTERNAL APPEALS

Complaints: A complaint is any dissatisfaction that a Member has with Molina or any Participating Provider that is not related to the denial of healthcare services. For example, a Member may be dissatisfied with the hours of availability of a Participating Provider. Issues relating to the denial of health care services are Appeals and should be filed with Molina or the Ohio Department of Insurance in the manner described in the Internal Appeals section below. Molina recognizes the fact that a Member may not always be satisfied with the care and services provided by our Participating Providers. Molina wants to know about concerns and any complaints Members may have. Molina will respond to a Member complaint no later than 60 days from the date Molina received it. A Member may contact Molina for assistance with filing a complaint over the phone, by mail or fax using the following contact information.

Molina Appeals and Grievances Department Address:

Molina Healthcare of Ohio, Inc.
Grievance and Appeals Unit
PO Box 182273
Chattanooga, TN 37422
Phone: (888) 296-7677, Monday – Friday 7:00 am – 7:00 pm EST
TTY: (800) 750-0750 or 711
Website: www.molinahealthcare.com

Member may also contact the Ohio Department of Insurance, Ohio Department of Insurance Consumer Affairs Address:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town St. Suite 300
Columbus, OH 43215
Phone: (800) 686-1526
Phone: (614) 644-2673
Fax: (614) 644-3744 TTY: (614) 644-3745
Website: https://insurance.ohio.gov
File Online Consumer Complaint:
https://insurance.ohio.gov/wps/portal/gov/odi/about-us/complaint-center/consumer-complaint-form

Definitions: For the purposes of this section, the following definitions apply:

Final Adverse Benefit Determination: An Adverse Benefit Determination that is upheld after the internal appeal process. If the period allowed for the internal appeal elapses without a determination by Molina, then the internal appeal will be deemed a Final Adverse Benefit Determination.

Appointing a Representative: If a Member would like someone to act on their behalf regarding a claim or an appeal of an Adverse Benefit Determination, the Member may appoint an authorized representative. Members should send the representative's name, address, and telephone contact information to the Molina Appeals and Grievances Department Address, listed in the Complaints section. Members must pay the cost of anyone the Member hires to represent or help the Member.

Claim Decisions: After a determination on a claim is made, Molina will notify the Member of its determination within the following timeframes:

Request Type	Timeframe for Decision and Notification
Pre-Service Claim	Within 48 hours for Urgent Care services, or 10 calendar days for any Prior Authorization request that is not for an Urgent Care Service, of the time the request is received. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform the Member of the reason for denial.)
Concurrent Service Claim	One business day from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform the Member of the reason for denial.)
Post-Service Claim	30 days from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform the Member of the reason for denial.)
Please Note: Additional information requests for Urgent Care Services will be made within 24 hours in accordance with State Law. If Medical Necessity is determined on Appeal and a Prior Authorization is required for the benefit, the determination will also include the authorization of the benefit in the determination	

Urgent Care Service Claim: A claim involving Urgent Care Services is processed as timely as possible given the circumstances and will always be processed within no more than 48 hours from receipt of request (if all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform Member of the reason for denial.), or if shorter, the period required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations.

Initial Denial Notices: Written notice of an Adverse Benefit Determination (including a partial claim denial) will be provided to Member within the time frames noted within this section. With respect to Adverse Benefit Determinations involving an Urgent Care Service, notice may be provided to Member orally within the timeframes noted within

this section. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

An Adverse Benefit Determination notice will identify the claim involved, convey the specific reason for the Adverse Benefit Determination (including the denial code and its meaning), the specific provisions upon which Molina based the determination, and the contact information for the Ohio Department of Insurance, which is available to assist Member with the internal and external appeal processes. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.

The notice will disclose if any internal policy, protocol, or similar criterion was relied upon to deny the claim. A copy of the policy, protocol, or similar criterion will be provided to Member, free of charge. In addition to the information provided in the notice, Members have the right to request the diagnosis, treatment codes and descriptions upon which the determination is based. The notice will describe Molina's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on review.

If an Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the product to Member medical circumstances. In the case of an Adverse Benefit Determination involving a claim for Urgent Care Service, the notice will provide a description of Molina's expedited review procedures, which Molina describes below.

Internal Appeals: Members must appeal an Adverse Benefit Determination within 180 days after receiving written notice of the denial (or partial denial). Members may appeal an Adverse Benefit Determination by means of written notice to Molina, in person, orally, or by mail, postage prepaid. Adverse Benefit Determinations for electronic Prior Authorizations are included. Member Appeals should include:

- The date of the Member Appeal
- Member name (please print or type)
- The date of the service Molina denied
- Member identification number, claim number, and Provider name as shown on the explanation of benefits

Members should keep a copy of the Appeal for their records because no part of it can be returned to Member. Members may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Services orally or in writing. In such case, all necessary information will be transmitted between Molina and the Member by telephone, fax, or other available similarly expeditious method, to the extent permitted by applicable law. Members may also request an expedited external review of an Adverse Benefit Determination involving an Urgent Care Service at the same time a request is made for an expedited internal appeal of an Adverse Benefit Determination if

the Member's Provider certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the Member's life or health, or would jeopardize the Member's ability to regain maximum function if treated after the time frame of an expedited internal appeal. Members may not file a request for expedited external review unless Members also file an expedited internal appeal. Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. The determination will consider all comments, documents, records, and other information submitted by the Member relating to the claim.

On appeal, Member may review relevant documents, request copies of any relevant information (which will be provided free of charge) and may submit issues and comments in writing. Upon request, Members may also discover the identity of medical or vocational experts whose advice was obtained on behalf of Molina in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If Molina bases the Adverse Benefit Determination in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, Molina will provide to Members, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide Member a reasonable opportunity to respond. However, if Molina receive the new or additional evidence so late that it would be impossible to provide it to Member in time for Member to have a reasonable opportunity to respond, the period for providing notice of Molina's appeal decision will be tolled until the Member has a reasonable opportunity to respond. After a Member responds or has a reasonable opportunity to respond but fails to do so, Molina will notify the Member of Molina's decision as soon as reasonably possible, considering the medical circumstances. Member coverage will remain in effect pending the outcome of Member internal appeal.

Timeframes for Decisions on Appeal: For appeals of Adverse Benefit Determinations, Molina will make decisions and provide notice of the decisions as follows:

Timeframe for Appeal Response	
Request Type	**Timeframe for Decision**
Urgent Care Service Decisions	Within 72 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a

	denial. Molina will inform the Member of the reason for denial.)
Pre-Service and Post-Service Decisions	Within 30 days from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform the Member of the reason for denial.)
Appeals from Adverse Prior Authorization or Step Therapy Decisions	• *Urgent:* within 48 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform the Member of the reason for denial.) • *Standard:* within 10 days from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform the Member of the reason for denial.)

Appeals Denial Notices: Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided to the Member by mail, postage prepaid, by fax or by e-mail, as appropriate and as required by State Law, within the time periods noted above. A notice that Molina have denied a claim appeal will include:

- Enough information to identify the claim involved;
- The specific reason or reasons for the Final Adverse Benefit Determination, including the denial code and its meaning;
- Reference to the specific product provision upon which the determination is based;
- A statement that Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Member claim for benefits;
- If Molina relied upon any internal Molina policy, protocol or similar criterion to deny the claim, then a copy of the policy, protocol or similar criterion will be provided to Member, free of charge, along with a discussion of the decision;
- A statement of Member right to external review, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing Molina to disclose protected health information pertinent to the external review; and
- If Molina bases a Final Adverse Benefit Determination on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide:

- An explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to Member medical circumstances.
- A notice of voluntary alternative dispute resolution options, as applicable

For assistance with appeals, complaints or the external review process, a Member may write or call the Ohio Department of Insurance Office of Consumer Affairs via the contact methods identified in this section. In addition to the information provided in the notice, Members have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

External Review: After Members receive a Final Adverse Benefit Determination or if Members are otherwise permitted, as described above, Members may request an external review if a Member believes that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service doesn't meet Molina's requirements for Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit, or is Experimental or Investigational.

An external review may be conducted by an Independent Review Organization (IRO) for Final Adverse Benefit Determinations involving Medical Necessity or medical judgment or by the Ohio Department of Insurance if the Final Adverse Benefit Determination involves a determination that the medical service is not covered by this Agreement. Molina will not choose or influence the IRO's reviewers. Members' coverage will remain in effect pending the outcome of the external review.

There are three types of IRO reviews: 1) standard external review, 2) expedited external review, and 3) external review of Experimental or Investigational treatment.

Standard External Review: A standard external review is normally completed within 30 days.

Expedited External Review: An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within 72 hours and can be requested if any of the following applies:

- Member's Provider certifies that the Adverse Benefit Determination or Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize Member life or health or would jeopardize Member ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review
- The Adverse Benefit Determination or Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which Member received Emergency Services, but have not yet been discharged from a facility; or

- An expedited internal appeal is in process for an Adverse Benefit Determination of Experimental or Investigational treatment and Member's Provider certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

External Review of Experimental and Investigational Treatment: Requests for standard or expedited external reviews that involve Adverse Benefit Determinations or Final Adverse Benefit Determinations for treatments that are Experimental or Investigational may proceed if the Member's Provider certifies one of the following:

- Standard health care services have not been effective in improving Member condition,
- Standard health care services are not medically appropriate for Member, or
- No available standard health care service covered by Molina is more beneficial than the requested health care service

Request for External Review in General: Members must request an external review within 180 days of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination issued by Molina. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. If the request is complete, Molina will initiate the external review and notify Members in writing that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. The notice will also inform Members that, within 10 business days after receipt of the notice, Members may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.

Molina will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable). If the request is not complete Molina will inform Members in writing and specify what information is needed to make the request complete. If Molina determines that the Adverse Benefit Determination is not eligible for external review, Molina will notify Members in writing, provide Members with the reason for the denial, and inform Members that the denial may be appealed to the Ohio Department of Insurance. The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Molina and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of this Agreement and State Law. Molina will pay the costs of the external review.

IRO Assignment: The Ohio Department of Insurance maintains a secure web-based system that is used to manage and monitor the external review process. When Molina initiates an external review by an IRO in this system, the Ohio Department of Insurance system randomly assigns the review to an Ohio accredited IRO that is qualified to conduct the review based on the type of health care service. Molina and the IRO are automatically notified of the assignment.

IRO Review and Decision: The IRO must forward, upon receipt, any additional information it receives from Members to Molina. At any time, Molina may reconsider its Adverse Benefit Determination and provide coverage for the healthcare service. Reconsideration will not delay or terminate the external review. If Molina reverses the Adverse Benefit Determination, Molina will notify Members, the assigned IRO and the Ohio Department of Insurance within 1 day of the decision. Upon receipt of the notice of reversal by Molina, the IRO will terminate the review.

In addition to all documents and information considered by Molina in making the Adverse Benefit Determination, the IRO must consider things such as; Members' medical records, the attending healthcare professional's recommendation, consulting reports from appropriate healthcare professionals, the terms of this Agreement and the most appropriate practice guidelines.

The IRO will provide a written notice of its decision within 30 days of receipt by Molina of a request for a standard review or within 72 hours of receipt by Molina of a request for an expedited review. This notice will be sent to Members, Molina and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the independent review organization's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

Binding Nature of External Review Decision: An external review decision is binding on Molina except to the extent Molina has other remedies available under State Law. The decision is also binding on Members except to the extent that Members has other remedies available under applicable State Law or federal law. Members may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Molina. If Members have questions about Members' rights or need assistance, Members may contact the Ohio Department of Insurance Consumer Affairs address in this provided in this section.

Ohio Department of Insurance External Review: Members may request an external review of a Final Adverse Benefit Determination by the Ohio Department of Insurance if Members believe that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service is not covered under this Agreement or Members are denied an external review of an Adverse Benefit Determination or Final Adverse Benefit Determination. Members may contact Molina to request an external review.

Non-Discrimination Notice – Section 1557
Molina Healthcare of Ohio - Marketplace

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin, race, or sex.

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes:(1) Qualified interpreters. (2) Information in other formats, such as large print, audio, accessible electronic formats, Braille.

- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes:(1) Qualified oral interpreters. (2) Information translated in your language.

If you need these services, contact Molina Member Services at 1-888-296-7677 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at MolinaHealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit
200 Oceangate, Suite 100
Long Beach, CA 90802
Email: Civil.Rights@MolinaHealthcare.com
Website: MolinaHealthcare.Alertline.com

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
TTY/TDD: 800-537-7697

Complaint forms are available here: https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

Notice of Availability – Section 1557
Molina Healthcare of Ohio - Marketplace

English	For free language assistance services, and auxiliary aids and services, call 1-888-296-7677 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-888-296-7677 (TTY: 711).
Chinese (Traditional) 中文（台灣繁體）	如需免費的語言協助服務以及輔助裝置和服務，請致電 1-888-296-7677 （聽障專線：711）。
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-888-296-7677 (TTY: 711).
Arabic العربية	اتصل عىل الرقم 1-888-296-7677 (الهاتف النص (TTY): 711) لتليق خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإلضافية.
Pennsylvanian Dutch Pennsylvanisch Deitsche	Fer koschdenlos Schprooch Helfe, un annere Helfe un Services, ruff 1-888-296-7677 (TTY: 711)
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-296-7677 (телетайп: 711).
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-888-296-7677 (ATS : 711).
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-888-296-7677 (TTY: 711).
Cushite Afaan Oromoo	Tajaajiloota hiikkaa afaanii, fi namoota hanqina dhagahuu qabaniif deeggarsa dhageettii meeshaatiinii bilisaan argachuuf, gara 1-888-296-7677 (TTY: 711) tti bilbilaa.
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-888-296-7677 (TTY: 711)로 연락 주시기 바랍니다.
Italian Italiano	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-888-296-7677 (TTY: 711).
Japanese 日本語	無料の言語サポートや補助器具・サービスをご希望の方は、1-888-296-7677（TTY: 711）までお電話ください。
Dutch Nederlands voor België	Voor gratis taalondersteuning, hulpmiddelen en diensten bel 1-888-296-7677 (TTY: 711).
Ukranian Українська	Для отримання безкоштовної мовної допомоги, допоміжних засобів та послуг телефонуйте за номером 1-888-296-7677 (TTY: 711).
Romanian Română	Pentru servicii de asistență lingvistică și servicii și ajutor suplimentar, apelați 1-888-296-7677 (TTY: 711).