Molina Healthcare of South Carolina, Inc.

Marketplace

2023

Agreement and Individual Evidence of Coverage

Right to Return: Newly enrolled Subscribers have the right to return this Agreement until midnight of the 30th day after the date on which the Subscriber receives the Agreement, by returning the Agreement to Molina or an agent of Molina. No reason need be stated for the return. Molina will treat this Agreement as if it had never been issued and will return all Premium Payments to the Subscriber. If the Subscriber returns this Agreement under this provision, they will be responsible for payment of any health care service they or a Dependent received before they returned the Agreement.

Service Area: Counties of Abbeville, Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Orangeburg, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, York.

Molina Healthcare of South Carolina
PO Box 40309
North Charleston, SC 29423

MSC01012023 SC23EOCE

Service	Need	Where to Go
Emergency Services	• Treatment of an Emergency Medical Condition	**Call 911**, or go to any Emergency room, even if it is a Non-Participating Provider or outside of the Service Area.
Getting Care	• Urgent care ▪ Minor illnesses ▪ Minor injuries • Virtual Care • 24-hour advice on medical and mental health questions	**24-Hour Nurse Advice Line** 1 (844) 800-5155 **Urgent Care Centers** Find a Provider or Urgent Care center MolinaMarketplace.com **Virtual Care** www.teladoc.com/molinamarketplace 1-800-TELADOC
Online Access	• Find or change a doctor • View benefits and Member Handbook • View or print ID card • Track claims	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaMarketplace.com
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card support • Access to care • Payment questions	**Molina Member Services** 1 (855) 885-3176 Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern **Go to** MyMolina.com **Go to** MolinaPayment.com
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report change of address or income	1 (800) 318-2596 **Go to** healthcare.gov

TABLE OF CONTENTS

THANK YOU FOR CHOOSING MOLINA 7

DEFINITIONS 8

ENROLLMENT AND ELIGIBILITY 12

- Open Enrollment Period 12
- Special Enrollment Period 13
- Dependents 13
- Adding New Dependents 13
- Discontinuation of Dependent Coverage 15
- Continued Eligibility 16

PREMIUM PAYMENT 16

- Advanced Premium Tax Credit (APTC) 16
- Payment 16
- Late Payment Notice 16
- Grace Period 16
- Termination Notification for Non-Payment 17
- Reinstatement 17
- Reinstatement after Termination 17
- Re-enrollment After Termination for Non-Payment 17
- Renewability of Coverage 18

TERMINATION OF COVERAGE 18

- Dependent and Child-Only Ineligibility Due to Age 18
- Member Ineligibility 18
- Non-Payment of Premium: 19
- Fraud or Intentional Misrepresentation 19
- Member Disenrollment Request 19
- Discontinuation of a Particular Product 19
- Discontinuation of All Coverage 19

ACCESS TO CARE 19

- For an Emergency, call 911 19
- Participating Provider Requirement 19
- Member ID Card 20
- Member Right to Obtain Health Care Services Outside of Policy 20
- Primary Care Provider (PCP) 20
- Telehealth Services 20
- Non-Participating Provider at a Participating Provider Facility 21
- No Participating Provider to Provide a Covered Service 21
- Continuation of Care (Continuity of Care) 21
- Transition of Care 22
- Referral 22
- Second Opinion 22
- Moral Objections 22
- Accessing Care for Members with Disabilities 22

PRIOR AUTHORIZATION 23

- Medical Necessity 24
- Utilization Review 24
- Inpatient Concurrent Review 25

COORDINATION OF BENEFITS (COB) 25

COST SHARING 29

COVERED SERVICES **30**
ESSENTIAL HEALTH BENEFITS 30
APPROVED CLINICAL TRIALS 31
CANCER TREATMENT 32
DENTAL AND ORTHODONTIC SERVICES 32
DIABETES SERVICES 32
DIALYSIS SERVICES 33
EMERGENCY SERVICES 33
Emergency Services When Out of Service Area 33
Emergency Services Rendered by a Non-Participating Provider 33
Post-Stabilization Services Rendered by a Non-Participating Provider 33
Transfer to a Participating Provider Hospital 34
EMERGENCY MEDICAL TRANSPORTATION 34
FAMILY PLANNING 34
HABILITATION SERVICES 34
HOME HEALTHCARE 35
HOSPICE SERVICES 35
INPATIENT HOSPITAL SERVICES 35
LABORATORY TESTS, RADIOLOGY (X-RAYS), AND SPECIALIZED SCANNING SERVICES 35
MENTAL HEALTH SERVICES (INPATIENT AND OUTPATIENT) 36
Autism Spectrum Disorder 36
Mental Health Parity and Addiction Equity Act 36
PHYSICIAN SERVICES 36
PREGNANCY AND MATERNITY 37
PREGNANCY TERMINATION 37
PREVENTIVE SERVICES 37
PROSTHETIC, ORTHOTIC, INTERNAL IMPLANTED AND EXTERNAL DEVICES 38
RECONSTRUCTIVE SURGERY 39
REHABILITATION SERVICES 39
SKILLED NURSING FACILITY 39
SUBSTANCE USE DISORDER (INPATIENT AND OUTPATIENT) 40
SURGERY (INPATIENT AND OUTPATIENT) 40
TRANSPLANT SERVICES 40
URGENT CARE SERVICES 41
VISION SERVICES 41
Pediatric Vision Services 41
Adult Routine Vision Services 41

PRESCRIPTION DRUGS **41**
DRUGS, MEDICATIONS AND DURABLE MEDICAL EQUIPMENT 41
PHARMACIES 42
MOLINA FORMULARY 42
ACCESS TO NON-FORMULARY DRUGS 42
REQUESTING AN EXCEPTION 42
COST SHARING 43
COST SHARING ON FORMULARY EXCEPTIONS 44
DRUG COST SHARING ASSISTANCE AND OUT-OF-POCKET COSTS 44
OVER-THE-COUNTER DRUGS, PRODUCTS AND SUPPLEMENTS 44
DURABLE MEDICAL EQUIPMENT (DME) 44
DIABETIC SUPPLIES 44
PRESCRIPTION DRUGS TO STOP SMOKING 44
DAY SUPPLY LIMIT 44
PRORATION AND SYNCHRONIZATION 45
OPIOID ANALGESICS FOR CHRONIC PAIN 45
DRUGS TO TREAT CANCER 45
TREATMENT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) 45

Mail Order Availability of Formulary Drugs 45
Off-Label Drugs 45
Non-Covered Drugs 46

EXCLUSIONS 46

CLAIMS 49

Filing a Claim 49
Claim Processing 49
Reimbursement 50
Paying Bills 50

LEGAL NOTICES 50

Third Party Liability 50
Workers' Compensation 51
Changes in Premiums and Cost Sharing 51
Acts Beyond Molina's Control 51
Waiver 51
Non-Discrimination 52
Agreement Binding on Members 52
Assignment 52
Invalidity 52
Notices 52
Continuation of Coverage (Divorce) 52
Time Limit on Certain Defenses 52
Proof of Loss Claim Form 52
Proofs of Loss 53
Proof of Loss Time of Payment of Claims: 53
Physical Examinations 53
Legal Action 53
Change of Beneficiary 53
Governing Law 53
Wellness and Other Program Benefits 53
Advance Directives 54

APPEALS AND GREIVANCES 54

Definitions 54
Complaints 55
Appointing a Representative 55
Initial Denial Notice 55
Internal Appeals 55
Time Frame for Internal Appeal Decisions 56
Exhaustion of the Internal Claims and Appeals Processes 56
External Review 56
Standard External Review 57
Expedited External Review 57
External Review of Experimental and Investigational Treatment 57
Request for External Review 57
IRO Assignment 57
IRO Review and Decision 57
Binding Nature of External Review Decision 57
State Regulator Assistance 58

NON-DISCRIMINATION NOTICE 59

Policy Issuance: This Molina Healthcare of South Carolina, Inc., Agreement and Individual Evidence of Coverage (also called the "Agreement") is issued by Molina Healthcare of South Carolina, 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 and the application available at https://marketplace.cms.gov/applications-and-forms/marketplace-application-for-family.pdf, 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.

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

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

THANK YOU FOR CHOOSING MOLINA

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

We're providing this Agreement to tell you:

- How you can get services through Molina, including:
  - 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 Member Services at MolinaMarketplace.com or at the phone number on page 2 of this Agreement.

We look forward to serving you!

Molina Marketplace

DEFINITIONS

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

Affordable Care Act: The comprehensive health care reform law enacted in March 2010 (sometimes known as “ACA” or “PPACA”)

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

1. *For Covered Services furnished by a Participating Provider:* These services shall be reimbursed at the contracted rate with the Participating Provider for such Covered Services.
2. *For certain Covered Services furnished by a Non-Participating Provider:* Subject to exceptions expressly permitted by law, the services described below shall be reimbursed at the out-of-network rate, as that term is defined and determined under applicable federal law:
    - Emergency Services furnished by a Non-Participating Provider
    - Post-Stabilization Services furnished by a Non-Participating Provider when such Covered Services are treated, for reimbursement purposes, as Emergency Services under applicable State Law or federal law
    - Air ambulance services furnished by a Non-Participating Provider; and
    - Covered Services furnished by a Non-Participating Provider during a visit at a Participating Provider that is a hospital, critical access hospital, ambulatory surgical center, or other facility required by law.

    In the case of exceptions expressly permitted by law, the Allowed Amount shall be determined in accordance with the procedures (including dispute resolution proceedings) or other requirements dictated by applicable state law, when federal law defers to state law in determining reimbursement amounts to Non-Participating Providers, or federal law, when federal law controls the reimbursement amount to Non-Participating Providers.
3. *For all other Covered Services furnished by a Non-Participating Provider in accordance with this Agreement:* Except if otherwise expressly required by applicable law, these services shall be reimbursed at the lowest of (a) Molina’s median contracted rate for such Covered Service(s), (b) 100% of the published Medicare rate for such Covered Service(s), (c) Molina’s usual and customary method for determining payment for such Covered Service(s), or (d) a negotiated amount agreed to by the Non-Participating Provider and Molina.

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

amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

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

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

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

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

Coinsurance: A percentage of the charges for Covered Services the Member must pay when they receive certain Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider (also known as the "contracted amount") or the Participating Provider's charge, if less than the contracted amount. If applicable, Coinsurances are listed in the Schedule of Benefits.

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

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

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

Deductible: The amount Members must pay for Covered Services before Molina begins to pay for Covered Services. The amount paid toward the Deductible is based on the rates that Molina has negotiated with the Participating Provider (also known as the "contracted amount") or the Participating Provider's charge, if less than the contracted amount. Please refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan.

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

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

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

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

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

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of 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 inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or child.

Emergency Transportation Services: Appropriate ambulance transfers undertaken prior to an Emergency Medical Condition being stabilized.

Emergency Services: Services to evaluate, treat or stabilize an Emergency Medical Condition. These services may be provided in a licensed emergency room or other facility that provides treatment of Emergency Medical Conditions.

Essential Health Benefits or EHB: A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Experimental or Investigational: Any medical service including procedures, medications, facilities, and devices that the FDA has not approved for treatment or therapeutic use in connection with underlying medical condition for which such procedure, medication, facility or device was prescribed.

FDA: The United States Food and Drug Administration.

Health Status-Related Factor: Any of the following factors: health status; medical condition, including both physical and mental illnesses and behaviors related to health status; claims experience; receipt of health or behavioral health care; medical history; genetic information; evidence of insurability, including contributions arising out of acts of domestic violence; or disability.

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

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

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

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

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

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

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

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

Participating Provider: A Provider (including a licensed podiatrist, oral surgeon, optometrist, or doctoral psychologist within their scope of practice) that furnishes any health care services and is licensed or otherwise authorized to furnish such services and contracts with Molina and has agreed to provide Covered Services to Members.

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

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

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), certified nurse practitioner, clinical nurse specialist, physician assistant, Rural Health Clinic (RHC), or Federally Qualified Health Center

(FQHC), as allowed under State Law and the terms of the Plan, who provides, coordinates, or helps a Member access a range of health care services.

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

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

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

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

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

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

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

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

ENROLLMENT AND ELIGIBILITY

An individual must be enrolled as a Member of this Plan for Covered Services to be available. To enroll and become a Member of this Plan, an individual must meet all eligibility requirements established by the Marketplace. An individual's eligibility for, or receipt of, medical assistance under Medicaid will not be considered in enrollment or the payment of benefits. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber for this Plan.

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

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

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

Dependents: Subscribers who enroll during the Open Enrollment Period established by the Marketplace may also apply to enroll eligible individuals as Dependents. Dependents must meet the eligibility requirements as established by the Marketplace. Non-child Dependents are subject to the terms and conditions of this Agreement. Molina does not limit Dependent eligibility based on financial dependency, residency, 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 son, daughter, adopted child, stepchild, foster child, or child under legal guardianship. Each child is eligible to apply for enrollment as a Dependent until the age of 26.
- **Child with a Disability:** A child who reaches the age of 26 is eligible to continue to be a Dependent if the child meets the following eligibility criteria:
  - The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
  - The child of any age is chiefly dependent upon the Subscriber for support and maintenance if the Child is permanently and totally disabled.
  - A child may remain covered by Molina as a Dependent for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.
- **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.
- **Grandchildren:** Subscriber's grandchildren do not qualify as Dependents of the Subscriber unless the Subscriber or Subscriber's spouse is a legal guardian or as otherwise required by law.

A dependent child will not be denied enrollment on the grounds that the child was born out of wedlock, is not claimed as a dependent on the parent's federal tax return; or does not reside with the parent or in the Service Area.

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

and submit any required applications, forms and requested information for the Dependent. A Member's request to enroll a new Dependent must be submitted to the Marketplace within 60 days from the date the Dependent became eligible to enroll in the Plan.

- **Spouse:** A Spouse may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
  - Loss of minimum essential coverage, as defined by the Affordable Care Act
  - The date of marriage to the Subscriber
  - The Spouse gains status as a citizen, national, or lawfully present individual
  - The Spouse permanently moves into the Service Area.

- **Children (Under 26 Years of Age):** Children may be added as a Dependent without regard to any enrollment season restrictions 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, court-appointed legal guardianship, child support, or other court order.
  - The Child gains status as a citizen, national, or lawfully present individual
  - The Child permanently moves into the Service Area.

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

  Please note: Claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Deductible or OOPM amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and OOPM. However, if an enrollment file is received for the newborn during the first 31 days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Deductible or OOPM amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or OOPM (i.e., not under the enrolled mother's Deductible and OOPM). A newborn's claim is a claim in which the newborn child is identified as the individual receiving services.

- **Court-Appointed Legal Guardianship, Court Order or Child Support Order:** If a child becomes a Dependent of the Subscriber or Subscriber's Dependent Spouse through a court-appointed legal guardianship, 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 without regard to any enrollment season restrictions subsequent to the court order or appointment of legal guardianship. The child shall be eligible for coverage on the date the court

order or appointment of legal guardianship is effective or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

If the Subscriber or Subscriber's Dependent Spouse is required to provide health care coverage for a child pursuant to a court order that meets the requirements of State Law and the enrolled parent fails to make application to obtain coverage for the child under this Agreement, then the following may apply for coverage on behalf of the child:

- The child's other parent;
- The state agency administering the Medicaid program; or,
- The state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program.

If the Subscriber or Subscriber's Dependent Spouse is a noncustodial parent of a covered dependent child, Molina shall:

- provide information to the custodial parent as may be necessary for the child to obtain benefits under this Agreement;
- permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
- make payments on claims submitted by the custodial parent or the health care provider, with the custodial parent's approval, directly to the custodial parent, the provider, or the state Medicaid agency.

Molina shall continue coverage of the child unless Molina is provided satisfactory written evidence that:

- the court order is no longer in effect; or
- the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the day after the effective date of disenrollment.

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

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

The Dependent discontinuing coverage is entitled to apply to the Marketplace for coverage, provided he or she meets the eligibility requirements of the Marketplace.

Upon the attainment of the limiting age, a child Dependent is entitled to have issued to him or her, without evidence of insurability, upon application made to the insurer within 30 days following the attainment of the age, and upon payment of the appropriate premium, an individual policy of health insurance that is closest to, but not greater than, the terminated coverage.

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

PREMIUM PAYMENT

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

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

Payment: Molina accepts Premium Payments online, by phone, by mail, and through money order. Please refer to MolinaPayment.com or contact Member Services for further information. Premium Payments are not accepted at Molina office locations. Molina accepts third-party premium payments from Ryan White HIV/AIDS programs, Indian tribes, tribal organizations, urban Indian organizations, and local, state or federal government programs, or as otherwise allowed by law.

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

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

- **Grace Period for Subscribers with APTCs:** Molina will provide a Grace Period of 3 consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, is receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services

rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for services in the second and third months of the Grace Period; Molina will terminate this Agreement as of 11:59 p.m. Eastern on the last day of the first month of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

- **Grace Period for Subscribers with No APTC:** Molina will provide a Grace Period of 31 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. Eastern on the last day of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

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

Reinstatement: If the renewal premium is not paid before the grace period ends the policy will lapse. Later acceptance of the premium by the company or by an agent authorized to accept payment without requiring an application for reinstatement will reinstate the policy. If the company or its agent requires an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty fifth day after the date of the conditional receipt unless the company has previously written the insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date.

In all other respects the rights of the insured and the company will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premiums the company accepts for reinstatement will be applied to a period for which premiums have not been paid.

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

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

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

Molina may nonrenew or discontinue coverage if a Subscriber no longer resides in an area for which Molina is authorized to do business, but only if the coverage is terminated uniformly without regard to any Health Status-Related Factor of covered individuals.

TERMINATION OF COVERAGE

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

Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium Payments received on behalf of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within 30 days. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation.

In lieu of returning to a Member the amount of Premiums paid to Molina which corresponds to any unexpired period and to the extent permitted by the Marketplace, if Molina accepts Premium which corresponds to any unexpired period following the date of termination, Molina will allow the Member to continue coverage in-force until the end of the period for which Premium has been accepted by Molina. Molina and its Providers will not have any further liability or obligation under this Plan.

Except as specified below, the Agreement will not terminate at a date other than the Agreement anniversary date or the premium due date. Molina may terminate or nonrenew a Member, upon 31 days' written notification, unless otherwise specified below, for any of the following reasons:

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

Member notification of loss of eligibility. The Member may request an earlier termination effective date.
- **Non-Payment of Premium:** Please refer to “Premium Payment” section
- **Fraud or Intentional Misrepresentation:** A Member has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with coverage. If the Member has committed Fraud or Intentional Misrepresentation, Molina may not accept enrollment from the Member in the future and may report any suspected criminal acts to authorities. Members may appeal the rescission of coverage.
- **Member Disenrollment Request:** Members may request disenrollment to the Marketplace. Coverage will terminate upon 14 days after the Member provides notice of their request for disenrollment.
- **Discontinuation of a Particular Product:** Molina decides to discontinue offering a product, in accordance with State Law. Molina will provide written notification of discontinuation at least 90 calendar days before the date the coverage will be discontinued.
- **Discontinuation of All Coverage:** Molina elects to discontinue offering all health coverage in a State in accordance with State Law. Molina will send Members written notification of discontinuation at least 180 calendar days prior to the date the coverage will be discontinued.

ACCESS TO CARE

For an Emergency, call 911. For an Emergency, Members may call an ambulance or go to any Emergency facility, even if it is a Non-Participating Provider or outside of the Service Area.
24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is 1 (844) 800-5155.

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 Emergency Services and Post Stabilization Services, or subject to Prior Authorization for the following:
- Exceptions described below under “Non-Participating Provider at a Participating Provider Facility”
- Exceptions described below under “No Participating Provider to Provide a Covered Service”
- Exceptions described below under “Continuation of Care (Continuity of Care)” section
- Exceptions described below under “Transition of Care” section

To locate a Participating Provider, please refer to the Provider directory at MolinaMarketplace.com or call Member Services. Because Non-Participating Providers are not in Molina's contracted Provider network, they may Balance Bill Members for the

difference between Molina's Allowed Amount and the rate that they charge. Members may avoid Balance Billing by receiving all Covered Services from Participating Providers.

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

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

Member Right to Obtain Health Care Services Outside of Policy: Molina does not restrict Members from freely contracting at any time to obtain any health care services outside this Agreement on any terms or conditions they may choose; however, Members will be 100% responsible for payment for such services, and the payments for such services will not apply to their Deductible or OOPM under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement.

Primary Care Provider (PCP): A Primary Care Provider (or PCP) takes care of routine and basic health care needs. PCPs provide Members with services such as physical exams, immunizations, or treatment for an illness or injury that is not needed on an urgent or emergency basis. Molina asks Members to select a PCP from the provider directory. If a PCP is not selected, one will be assigned by Molina. Members can request to change their PCP at any time at MyMolina.com or by contacting Member Services. Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP with no referrals required.

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

- The PCP is no longer a Participating Provider with Molina.
- The PCP is no longer accepting new or additional patients at this time.

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

- Must be obtained from a Participating Provider
- Are meant to be used when care is needed now for non-Emergency medical issues
- Are a method of accessing Covered Services, and not a separate benefit

- Are not permitted when the Member and Participating Provider are in the same physical location
- Do not include texting, facsimile or email only
- Covered Services provided through store-and-forward technology must include an in-person office visit to determine diagnosis or treatment.

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

- Medically Necessary
- Prior Authorized
- A Covered Service

Non-Participating Providers delivering services in a Participating Provider hospital may include, but are not limited to, pathologists, radiologists, and anesthesiologists. Molina will reimburse the Non-Participating Provider for these services up to the Allowed Amount. The Member will be responsible for any applicable Cost Sharing described in the Schedule of Benefits.

No Participating Provider to Provide a Covered Service: If there is no Participating Provider that can provide a non-Emergency Medically Necessary Covered Service, Molina will allow the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the Covered Service when rendered by a Participating Provider. Prior Authorization is required before the initiation of the service by a Non-Participating Provider.

Continuation of Care (Continuity of Care)

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

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

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

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

- if the Member becomes ineligible for coverage

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

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

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

Referral: A Member's PCP may send the Member to another Provider for a specific Covered Service. This process is a Referral.

Second Opinion: A Member or 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.

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

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

Members with disabilities should contact Member Services to request reasonable accommodation assistance

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

Access for the Speech- or Hearing-Impaired: Call Member Services at the TTY 711 number for assistance.

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important product materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available. This Agreement is also available in an audio format. For accessible formats, or for direct help in reading the Agreement and other materials, please call Member Services.

Disability Access Grievances: If a Member believes Molina or its doctors have failed to respond to their disability access needs, they may file a grievance with Molina. Please refer to the Appeals and Grievances section of this Agreement for information regarding how to file a grievance.

PRIOR AUTHORIZATION

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

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

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

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

PA rules may change. Members should contact Member Services or visit MolinaMarketplace.com/SCGetCare prior to receiving certain services

PA Timeframes

Medical Services:

- **Routine PA Requests:**
  - Not to exceed 5 business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. The period of time may be shorter if required by law.
- **Urgent PA Requests:**
  - Not to exceed 72 hours from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. The period of time may be shorter if required by law.
  - 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.

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 "Access to Non-Formulary Drugs."

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

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

Molina will not approve a Prior Authorization if information requested in connection with reviewing the Prior Authorization is not provided. If a service request is not Medically Necessary, it will not be approved. If the service requested is not a Covered Service, it will not be approved. Members will get written notification informing them why the Prior Authorization request was not approved. The Member, the Member's authorized representative or their Provider may appeal the decision. The denial decision letter will inform Members of the process to appeal the denial decision. These instructions are in the section of this Agreement titled "Complaints and Appeals." Members may obtain the clinical review criteria used to determine Medical Necessity for authorization requests by contacting Member Services.

If a Member decides to proceed with a service that has been denied or is not a service covered by this Agreement, the Member is responsible for the cost of that service.

Utilization Review: Licensed Molina staff processes Prior Authorization requests. Providers submit Prior Authorization requests on a member's behalf via Molina's online Provider e-portal or by fax. Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations

upon request. Molina provides assistance and informs Members of alternatives for care when a Member is not authorized for a service.

Inpatient Concurrent Review: Molina conducts concurrent review on inpatient cases.

- For non-Emergency admissions, a Member, their Provider, or the admitting facility will need to request precertification at least 14 days before the date the Member is scheduled to be admitted.
- For an Emergency admission, a Member, their Provider, or the admitting facility should notify Molina within 24 hours after the Member has been admitted.
- For outpatient and inpatient non-Emergency medical services requiring Prior Authorization, a Member, their Provider, or the admitting facility must notify Molina at least 14 days before the outpatient care is provided, or the procedure is scheduled.

COORDINATION OF BENEFITS (COB)

This provision applies when a person has health care coverage under more than one plan. Plan is defined below. The order of benefit determination rules governs the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do 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 determines 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: The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married: (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree; (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits; (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
   - The plan covering the custodial parent;
   - The plan covering the spouse of the custodial parent;
   - The plan covering the non-custodial parent; and then
   - The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

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

Effect on the Benefits of this Plan:
A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

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

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

COST SHARING

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

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

A Member is not required to pay more than the Provider's billed fees negotiated with Molina for Covered Services. If a Provider's fee is less than the applicable Copayment amount listed on the Schedule of Benefits, the amount a Member pays for Covered Services will constitute the applicable Cost Sharing.

COVERED SERVICES

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

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

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

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB) as defined by the Affordable Care Act (ACA) and its corresponding federal regulations. Services that are not EHBs will be specifically described in this Agreement. EHB coverage includes at least the 10 categories of benefits identified in the ACA and its corresponding federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. Eastern on the last day of the month that they turn age 19. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage. Under the ACA and its corresponding federal regulations governing EHBs:

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

not exceed an annual limit that is determined under the ACA.

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

Approved Clinical Trials: Molina covers routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition. A Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Members will never be enrolled in a clinical trial without their consent.

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

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

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

of care for the patient's diagnosis. All approvals and Prior Authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. Members will pay the Cost Sharing they would pay if the services were not related to a clinical trial. Members should contact Member Services for further information.

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

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer. Coverage allows at least 48 hours of hospitalization following a mastectomy. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending physician.
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more information)

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

- Dental services for radiation treatment
- Dental anesthesia when Medically Necessary
- Dental and Orthodontic services for cleft palate
- Dental services needed due to accidental injury

Molina covers Medically Necessary care and treatment for cleft lip and palate, as well as for any condition or illness which is related to or developed as a result of a cleft lip and palate, as required by State Law.

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

- Diabetes self-management training and education when provided by a Participating Provider
- Diabetic eye examinations (dilated retinal examinations)
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting
- Outpatient self-management training
- Routine foot care for Members with diabetes (including for care of corns, bunions, calluses, or debridement of nails).

- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Preventive Services including:
    - Diabetes (Type 2) screening
    - Screening for gestational diabetes
- Dietitian services
- Nutritional counseling

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

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

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

Emergency Services

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

Emergency Services When Out of Service Area: Members should go to the nearest Emergency room for care when outside the Molina Service Area when they think they are having an Emergency. Please contact Member Services within 24 hours or as soon as possible. Members should refer to the Cost Sharing for Emergency Services in the Schedule of Benefits.

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.

Important: Except as otherwise required by State Law, when Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, claims for Emergency Services will be paid at Molina's Allowed Amount. Non-Participating Providers may not Balance Bill Members for the difference between Molina's Allowed Amount and the rate that they charge for Emergency Services and associated Post-Stabilization Services.

Post-Stabilization Services Rendered by a Non-Participating Provider: Except as set forth below when transfer to a Participating Provider Hospital is appropriate, or when any other benefit exclusions apply, Molina covers Post-Stabilization Services obtained from Non-Participating Providers in accordance with State and Federal law. Covered Post-Stabilization Services, whether from Participating Providers or Non-Participating

Providers, are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits at the in-network level. Members are not subject to Balance Billing for Post-Stabilization Services unless they consent to waive Balance Billing protections according to the required process under federal law.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get hospital services, except in the case of Emergency Services and Post-Stabilization Services. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina reserves the right to exclude benefits for the services once the Member has Stabilized sufficiently and it is appropriate to transfer the Member to a Participating Provider facility. Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility.

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

Emergency Medical Transportation: Emergency medical transportation (ground and air ambulance), or ambulance transport services provided through the 911 emergency response system are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. For ground Ambulance, Members may be responsible for Balance Billing charges that exceed the Allowed Amount covered under this benefit for emergency medical transportation services rendered by a Non-Participating Provider. Emergency medical transportation outside of the United States is not covered.

Family Planning: Molina covers family planning services, including:

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

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These

include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

- In-home medical care services
- Home health aide services
- Medical social services
- Medical supplies
- Necessary medical appliances
- Nurse visits and part-time skilled nursing services
- Physical, occupational, speech or respiratory therapy
- Up to four hours per visit by a home health aide, and up to two hours per visit by a nurse, medical social worker, physical, occupational, or speech therapist
- Limited to 60 visits per calendar year for all visit types

Hospice Services: Molina covers hospice services for Members who are terminally ill (a life expectancy of 12 months or less). Members can choose hospice care instead of the traditional services covered by this Plan. Molina covers home hospice services and a semi-private room in a hospice facility. Coverage includes palliative care. Molina also covers respite care up to seven days per occurrence. Respite is short-term inpatient care provided in order to give relief to a person normally providing care.

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

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

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

Mental Health Services (Inpatient and Outpatient): Molina covers a continuum of Mental Health Services when provided by Participating Providers and facilities acting within the scope of their license. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria. Molina may require authorization for coverage of services, including inpatient and certain outpatient services. Emergency involuntary admissions do not require Prior Authorization; however, the admitting facility must notify Molina of the admission, which is subject to meeting Medical Necessity criteria.

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.

Outpatient care for treatment of mental health disorder does not include primary therapy or counseling for any of the following: career, marriage, drug, divorce, 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
- Partial hospitalization programs for mental health
- Intensive outpatient programs for adults and day treatment for children
- Psychological and neuropsychological testing
- Behavioral health procedures

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

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 on medical or surgical benefits.

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

- Office visits, including:
    - Associated medical supplies

    - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician's office, an outpatient or an inpatient setting.
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy (covered based on the type of service and where it is received)
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care.
- Sleep studies (Separate facility Cost Sharing may apply)
- Dermatology office visits without a referral

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

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia;
- Laboratory services
- Inpatient hospital care without Prior Authorization for 48 hours after a normal vaginal delivery, not including the day of delivery, or 96 hours following a delivery by Cesarean section (C-section), not including the day of surgery. Longer stays require that Members or Member's Provider notifies Molina.

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

Pregnancy Termination: Pregnancy termination, to the extent permitted by State Law and Federal law is only covered when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused or arising from the pregnancy, or when the pregnancy is the result of rape or incest.

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

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

- Those evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task

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

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. 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. Coverage includes screening mammograms, cytological screening (pap smear), and prostate cancer examinations in accordance with State Law.

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

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

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

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

sections (as applicable) of the Schedule of Benefits to see the Cost Sharing applicable to internally implanted devices.

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

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

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

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

The following reconstructive surgery services are not covered:

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

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, psychiatric rehabilitation, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, and spinal manipulative therapy services in a variety of inpatient and/or outpatient settings. Outpatient physical therapy, speech therapy, and occupational therapy are limited to 30 visits per therapy type per year.

Skilled Nursing Facility: Molina covers 60 days per Plan year at a skilled nursing facility (SNF) for a Member when the SNF is a Participating Provider and the services are Prior Authorized before they begin. Covered SNF services include:

- Room and board
- Physician and nursing services

- Medications and injections

Substance Use Disorder (Inpatient and Outpatient): Molina covers Medically Necessary inpatient and outpatient treatment for substance use disorder. Inpatient coverage, in a Participating Provider hospital, is only covered for medical management of withdrawal symptoms. Molina also provides coverage for substance use disorder treatment in a short-term residential programs 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 abuse counseling
- Individual substance abuse evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs)

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

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 surgical drugs
- Discharge planning
- Operating and recovery rooms

Outpatient surgery services provided in any of the following locations:
- Outpatient or ambulatory surgery center
- Hospital operating room
- Clinic
- Physician’s office

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

Transplant Services: Molina covers certain transplants of organs or stem cell/bone marrow at participating Molina Centers of Excellence or at a Molina approved facility when Prior Authorization requirements are met. Molina criteria for transplant evaluation must be met before a transplant assessment is authorized. If a Center of Excellence determines that a Member does not satisfy Molina criteria for the future transplant, Molina will only cover the transplant evaluation services. The transplant Center of Excellence or Molina approved facility is responsible for all activities related to the transplant, including organ acquisition or stem cell/bone marrow donor cells. If a living

donor transplant is pursued for a Molina member, Molina will cover certain donation-related services for a donor, if the donor's insurance does not cover it. 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 or stem cell/bone marrow, and the treatment of complications. Molina guidelines for donor services are available by calling Member Services.

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

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

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

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

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

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

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

Laser corrective surgery is not covered.

PRESCRIPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Molina covers drugs ordered by Providers, approved by Molina, and filled through a pharmacy that is a Molina

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

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

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

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

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

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

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

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

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

Cost Sharing: Molina puts drugs on different levels called tiers based on how well they improve health and their value compared to similar treatments. The Plan pharmacy benefit has six Cost Sharing levels. For Tiers 1 through 4, the lower the Tier, the lower the Member's share of the cost will be. The Schedule of Benefits shows Member Cost Sharing for a one-month supply based on these tiers. Here are some details about which drugs are on which tiers:

Drug Tier	Description
Tier 1	Preferred Generic drugs; Lowest Cost Sharing.
Tier 2	Preferred Brand-Name drugs; Higher Cost Sharing than Tier 1
Tier 3	Non-Preferred Brand-Name and Generic drugs; Higher Cost Sharing than lower tier drugs used to treat the same conditions.
Tier 4	All Specialty Drugs, Brand-Name and Generic; Higher Cost Sharing than lower tier drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use the network specialty pharmacy.
Tier 5	Nationally recognized preventive service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 Cost Sharing.

DME	Durable Medical Equipment (“DME”) – Cost Sharing applies; some non-drug products on the Formulary have Cost Sharing determined by the DME Cost Sharing.

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

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

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

Durable Medical Equipment (DME): Molina will cover DME rental or purchase costs, including for use with certain drugs, when obtained through a contracted vendor. Molina will also cover reasonable repairs, maintenance, delivery, and related supplies for DME. Members may be responsible for necessary DME repair or replacement costs if needed due to misuse or loss of the DME. The Cost Sharing amounts as listed on your Schedule of Benefits apply per purchase or rental period. Prior Authorization may be required for DME to be covered. Coverage may be under the medical benefit or the pharmacy benefit, depending on the type of DME. Please refer to the Formulary for DME and other non-drug products covered under the pharmacy benefit. Please refer to MolinaMarketplace.com, or contact Member Services 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. Members should consult their Provider to determine which drug is right for them. Covered drugs are listed on the Formulary.

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

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

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

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs and their administration. Prior authorization requests for drugs to be used outside the FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity. These requests are reviewed against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on non-FDA label use. Drugs that Providers treat Members with will be subject to Cost Sharing specified for chemotherapy under the medical benefit for the site where treatment is given. Drugs that Members get from pharmacies will be subject to Cost Sharing specified for the pharmacy benefit. Please refer to the Schedule of Benefits for applicable Cost Sharing. Most new anti-cancer drugs require special handling and education and are considered Tier 4 specialty drugs under the pharmacy benefit.

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

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

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

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

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

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

EXCLUSIONS

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

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.

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

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

Dietitian: A service of a dietitian is not a covered benefit. This exclusion does not apply to services under hospice care, diabetes services or cardiac rehabilitation therapy.

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

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

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

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

Illegal Occupation: The company is not liable for any loss which results from the insured committing or attempting to commit a felony or from the insured engaging in an illegal occupation.

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

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

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

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills, teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching Members how to read, if they have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional-growth courses

- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy
- Examinations related to job, athletic (sports physicals), or recreational performance

Massage Therapy: Massage therapy is not covered.

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

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

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

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

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

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

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

Services Provided Outside the Service Area: Any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. Only Emergency Services outside the Service Area are covered to treat an Emergency Medical Condition. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Member Services for more information.

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

Services Related to a Non-Covered Service: When a service is not covered, all services related to the non-Covered Service are not covered. This exclusion does not apply to services Molina would otherwise cover to treat complications of the non-Covered Service. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service.

For example, if a Member has a non-covered bariatric surgery or cosmetic surgery, Molina would not cover services the Member receives in preparation for the surgery or for follow-up care. If the Member later suffers a complication such as a serious infection, this exclusion would not apply and Molina would cover any services that would otherwise be covered as Medically Necessary to treat that complication.

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

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

Travel and Lodging Expenses: In general, 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 Member Services.

CLAIMS

Filing a Claim: Members or 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 45 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to Molina within these timelines are not 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 45 calendar days after receipt of a claim submitted

with all relevant medical documentation and that complies with Molina billing guidelines and requirements. The receipt date of a claim is the date Molina receives either written or electronic notice of the claim.

Time of Payment of Claims: After receiving written proof of loss, Molina will pay within 40 business days for claims submitted via paper and within 20 business days for claims submitted electronically, following receipt of both the request for reimbursement and all information necessary to process the claim and determine that such claim does not contain any material defect, error, or impropriety, all benefits then due for the Plan year for this Agreement.

Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was approved or does not require approval, Molina will repay the Member. Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. Members must mail this information to Molina Member Services at the address on the first page of this Agreement. The Member will need to mail Molina a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number.

If the bill is for a prescription, the Member will need to complete a Reimbursement Form found on the Member portal at MyMolina.com. Include a copy of the prescription label and pharmacy receipt when submitting this form to the address as instructed in the form.

After Molina receives the request for reimbursement, Molina will respond to the Member within 30 calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member.. If the claim is denied, Molina will send the Member a letter explaining why. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

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

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

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

LEGAL NOTICES

Third Party Liability: Molina is entitled to reimbursement for any Covered Services provided for a Member under this plan to treat an injury or illness caused by the wrongful act, omission, or negligence of a third party, if a Member has been made whole for the injury or illness from the third party or their representatives. Molina shall

be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries, and the Member shall cooperate to fully and completely assist in the protection the rights of Molina, including providing prompt notification of a case involving possible recovery from a third party. Members must reimburse Molina for the reasonable cost of services paid by Molina to the extent permitted by State Law immediately upon collection of damages by the Member, whether by action or law, settlement or otherwise; and fully cooperate with Molina's effectuation of its lien rights for the reasonable value of services provided by Molina to the extent permitted under State Law. Molina's lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

Reimbursement to Molina described in this Third-Party Liability section shall not exceed the amount of benefits that Molina paid in relation to the Member's injury or illness caused by the liable other person or third party. The Member has the right to petition the Director of Insurance, or his designee, to determine if Molina's subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it is not allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by South Carolina law. Molina will pay attorney's fees and costs from the amount recovered.

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

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

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

Waiver: Molina's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement or

impair Molina's right to require a Member's performance of any provision of this Agreement.

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

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

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 in Molina's discretion.

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

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

Continuation of Coverage (Divorce): Upon the entry of a valid decree of divorce between the Subscriber and their insured Spouse, the Spouse is entitled to have issued to him or her, without evidence of insurability, upon application made to the insurer within 60 days following the entry of the decree, and upon payment of the appropriate premium, an individual policy of health insurance. The policy shall provide the coverage then being issued by the insurer, which is most nearly similar to, but not greater than, the terminated coverages. Any probationary or waiting periods set forth in the policy are considered as being met to the extent coverage was in force under the prior policy.

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 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.

Proof of Loss Claim Form: Molina, upon receipt of a notice of claim, will provide such forms as are usually provided by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the Member shall be deemed to have complied with the requirements of this Agreement as to proof of loss upon submitting, within the time fixed in the Agreement for filing proofs of loss, written proof

covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Molina at its said office in case of claim for loss for which this Agreement provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which Molina is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Proof of Loss Time of Payment of Claims: Benefits will be paid to the Member. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Member's estate. Any other benefits unpaid at death may be paid, at Molina's option, either to the Member's beneficiary or estate.

Physical Examinations: Molina, at its own expense, may have the Member examined as often as reasonably necessary while a claim is pending. In cases of Member death, Molina, at its own expense, may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

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 6 years after the time written proof of loss is required to be furnished.

Change of Beneficiary: Unless the Member makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of benefits or Claims under this Agreement or to any change of beneficiary or beneficiaries, or to any other changes in this Agreement. However, unless Molina has reliable, written documentation of a Member's lawful designated beneficiary, Molina reserves the right to pay claims for money due, benefits or claims owing under this Agreement only to the Subscriber or applicable Member (as determined by Molina) and to refuse to honor any assignment of monies, benefits or Claims under this Agreement.

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 Law or federal law shall bind Molina and Members whether or not set forth in 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. The rewards and program benefits available to you may include premium credits or 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. For more information, please contact Member Services.

Advance Directives: An Advance Directive is a form that tells medical providers what kind of care you want if you cannot speak for yourself. An Advance Directive is written before you have an Emergency. This is a way to keep other people from making important health decisions for you if you are not well enough to make your own. A "Durable Power of Attorney for Health Care" and a "Natural Death Act Declaration" are types of Advance Directives. You have the right to complete an Advance Directive. Your provider can answer questions about Advance Directives. You may call Molina to get information regarding State Law on Advance Directives, and changes to Advance Directive laws. Molina updates Advanced Directive information no later than 90 calendar days after receiving notice of changes to State Laws. For more information, call Member Services.

APPEALS AND GREIVANCES

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

"Authorized Representative" means an individual who is authorized to act on a Member's behalf with respect to an appeal, either by law or in accordance with Molina's processes.

"Adverse Benefit Determination" means any of the following:

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan;
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- Any decision by Molina to rescind coverage after the member has become covered under the plan.

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

"Urgent Care Service" means a medical service where the application of non-Urgent Care Service time frames:

- Could seriously jeopardize a Member's life, health, ability to regain maximum function, or unborn child; or

- In the opinion of the treating physician, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Complaints: A complaint is any dissatisfaction with Molina or any Participating Provider that is expressed by a Member or their Authorized Representative and that is not related to the denial of healthcare services. A complaint is also called a “grievance.”

A Member or a Member’s Authorized Representative may file a complaint by phone by calling Molina Member Services at the toll-free phone number on page 2 of this Agreement. Members can submit a complaint in writing, along with any supporting materials, to Member Appeals and Grievances at the Molina mailing address on the first page of this Agreement.

Molina provides written acknowledgement of complaints and responds to complaints no later than 90 days from when the complaint was received. This period may be extended if there is a delay in obtaining the documents or records that are necessary to resolve the complaint or if the Member and Molina agree in writing to extend the period.

Pending the resolution of a complaint, Molina will not terminate a Member’s coverage for any reason that is the subject of the complaint, except that Molina does have the right to terminate coverage where Molina has made a good faith, reasonable effort to resolve the complaint and termination is otherwise permitted by the terms of this Agreement.

Appointing a Representative: If a Member would like someone to act on their behalf regarding an appeal of an Adverse Benefit Determination, the Member may appoint an Authorized Representative. The Member should send the Authorized Representative’s name, address, and telephone contact information to Member Appeals and Grievances at the address shown on the first page of this Agreement.

Initial Denial Notice: Members will be provided with a notice of Adverse Benefit Determination by phone, by mail, by fax or by e-mail, as appropriate. An Adverse Benefit Determination notice will identify the claim or authorization request involved. It will give the specific reason for the Adverse Benefit Determination (including the denial code and its meaning) and the specific product provisions upon which the determination was based. It will also include the contact information for the South Carolina Department of Insurance, which is available to assist with the internal and external appeal processes. Upon request, a copy of the rule, protocol, or similar criterion relied upon to deny the claim or authorization request will be provided, free of charge. The notice will describe Molina's internal and external (standard and expedited) appeal procedures, the time limits applicable to such procedures following an Adverse Benefit Determination and will include a release form authorizing Molina to disclose protected health information pertinent to an external review.

Internal Appeals: Adverse Benefit Determinations must be appealed within 180 days after receiving written notice of the denial (or partial denial). Members may appeal an Adverse Benefit Determination by means of notice to Molina either in person, by phone, or by mail.

The request should include:
- The date of the request.
- Member’s name (please print or type).
- The date of the denied service.
- The Member’s identification number, claim or Prior Authorization number, and Provider name.

Members may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Service.

Determination of appeals of Adverse Benefit Determinations will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. Members have the right to request that the person performing the review must practice the same profession as the attending health care provider.

Time Frame for Internal Appeal Decisions: Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided as follows. For pre-service appeals, Molina will notify the Member and/or Authorized Representative (if applicable) in writing of the resolution of the appeal within 30 calendar days after receipt of the appeal. For post-service appeals, resolution will be provided in writing within 60 calendar days from receipt of the appeal. For expedited appeals (for Urgent Care Service decisions), Molina will give oral notice of the resolution as soon as possible, considering the medical circumstances, but not later than 72 hours after Molina’s receipt of the appeal or 2 business days after Molina’s receipt of all information necessary to complete the appeal.

Exhaustion of the Internal Claims and Appeals Processes: A request for standard or expedited external review cannot be made until Molina’s internal appeals process has been exhausted (completed) and a Final Adverse Benefit Determination has been provided, unless 1) Molina provides a waiver of this requirement, 2) Molina fails to follow the internal appeal process, or 3) if the Member files a request for an expedited external review at the same time as an internal expedited grievance involving an Urgent Care Service as certified by the treating Provider.

External Review: After receipt of a Final Adverse Benefit Determination or if otherwise permitted, as described above, a Member may request an external review if they believe 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, health care setting, level of care, effectiveness of a covered benefit, or is Experimental or Investigational. The Member must authorize the release of any medical records required for reaching a decision on the external review.

An external review will be conducted by an Independent Review Organization (IRO). Molina will not choose or influence the IRO’s reviewers. Molina will pay the costs 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: The IRO will provide written notice of its decision within 45 calendar days of its receipt of the request for standard external review.

Expedited External Review: Expedited reviews for an Urgent Care Service, including reviews of Experimental or Investigational treatment involving an Urgent Care Service are normally completed within 72 hours. Expedited review can be requested for Urgent Care Service as certified by the treating Provider or concerning Emergency Services for which the Member has not yet been discharged.

External Review of Experimental and Investigational Treatment: For a standard or expedited external review for a determination that a treatment is Experimental or Investigational, the treating Provider must be qualified in the relevant area of medicine and must certify that the treatment is medically appropriate.

Request for External Review: Requests must be made, in writing, within 4 months of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination for a standard review. A request for an expedited external review has no filing deadline. Members can submit a written request for external review, along with any supporting materials, to the Molina mailing address on the first page of this Agreement.

IRO Assignment: When Molina initiates an external review, the South Carolina Department of Insurance will utilize an impartial and independent rotational system to assign the review to a South Carolina accredited Independent Review Organization (IRO) that is qualified to conduct the review based on the type of health care service. Molina will verify that no conflict of interest exists with the IRO.

IRO Review and Decision: Within 5 business days after the IRO's receipt of a request for standard external review, the IRO will determine whether the request is eligible for external review and confirm that all information, forms and certifications were provided. The IRO will notify the Member immediately if additional information is required. If the request is not accepted for standard external review, the IRO will provide the Member and Molina with written notice explaining the reason. The IRO will notify the Member and Molina if the request is accepted for standard external review. This paragraph does not apply to expedited external reviews.

The IRO will provide written notice of its decision within 45 calendar days of its receipt of the request for a standard review. The IRO will provide notice of an expedited review decision within 72 hours of receipt by Molina of a request for an expedited review. If the expedited review decision is not in writing, written notice will be provided within 48 hours of providing the oral notice.

If the IRO reverses the Adverse Benefit Determination or Final Adverse Benefit Determination, Molina will approve a covered benefit that was the subject of a standard request within 5 business days of receipt of the notice from the IRO, and as quickly as reasonably possible for an expedited request, subject to applicable exclusions, limitations, or other provisions of this Agreement.

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 the Member except to the extent that they have 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

State Regulator Assistance: For questions about Member rights or for assistance with complaints, with the internal claims and appeals process or with the external review process, Members may contact the South Carolina Department of Insurance at the following:

Consumer Services Division
P.O. Box 100105
Columbia, SC 29202-3105
Phone: 1 (803) 737-6180 or 1 (800) 768-3467
Fax: 803-737-6231
E-mail: consumers@doi.sc.gov
Online complaint form: https://doi.sc.gov/consumers

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

03/11/19 - Global

9784770CORP0218

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجانًا لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Զանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում: (Armenian)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه! اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان در اختیار شما است. با خدمات اعضاء تماس بگیرید. شماره تلفن مربوطه در پشت کارت عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ. ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប្រ៊ែលឬពុម្ពអក្សរធំដោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកដោយមិនគិតថ្លៃបន្ថែម។ (Cambodian)