Molina Healthcare of Washington, Inc. Marketplace

2023

Agreement and Individual Evidence of Coverage

Molina Healthcare of Washington, Inc.
21540 30th Dr. SE, Suite 400
Bothell, WA 98021

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MOLINA REFERENCE GUIDE

Service	Need	Where to Go
Emergency Services and Behavioral Health Emergency Services	• Treatment of an Emergency Medical Condition	**Call 911**, or go to any hospital Emergency room, even if it is a Non-Participating Provider or outside of the Service Area.
Getting Care	• Annual exams and check-ups	**Call your Primary Care Provider**
	• Healthcare advice 24 hours a day, 365 days a year.	**24-Hour Nurse Advice Line** 1 (888) 275-8750 (English) 1 (866) 648-3537 (Spanish)

	• Urgent Care
	  ○ Minor Illnesses
	  ○ Minor Injuries
		Urgent Care Centers
		Find a provider or Urgent Care facility
		MolinaMarketplace.com

	• Virtual Care	**Virtual Care** Teladoc.com/MolinaMarketplace 1-800-TELADOC
Online Access	• Find or change your 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 • Request Molina Member materials • ID card support • Access care • Prenatal care • Well-infant visits • Payment Questions	**Go to** MyMolina.com **Molina Customer Support Center** Molina Healthcare of Washington 21540 30th Dr. SE, Suite 400 Bothell, WA 98021 1 (888) 858-3492 Monday through Friday, 8:00 a.m. to 6:00 p.m. Pacific time **Go to** MolinaPayment.com
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report change of address or income	**Washington Healthplanfinder** www.wahealthplanfinder.org **Phone:**1-855-923-4633 **TTY:**1-855-627-9604

Interpreter Services: Molina offers interpreter services for any Member who may need language assistance to understand and obtain health coverage information 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

Agreement Issuance: This Molina Healthcare of Washington, Inc. Agreement and Individual Evidence of Coverage ("Agreement") is issued by Molina Healthcare of Washington, 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, riders to this Agreement, the applicable Schedule of Benefits for this Plan, and any application(s) submitted to the Health Benefit Exchange and/or Molina to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the entire legally binding contract between Molina and the Subscriber.

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

Privacy Practices: For a full explanation of how Molina protects your privacy, please go to the Molina Marketplace website.

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 Pacific time zone of the United States of America

Right to Return: Newly enrolled Subscribers have the right to return this Agreement until midnight of the tenth day after the date on which the Subscriber receives the Agreement, by returning the Agreement to Molina or an agent of Molina. No reason need be stated for the return. Molina will treat this Agreement as if it had never been issued and will return all Premium Payments to the Subscriber. If the Subscriber returns this Agreement under this provision, they will be responsible for payment of any health care service they or a Dependent received before they returned the Agreement. An additional ten percent (10%) penalty shall be added to any premium refund due which is not paid within thirty (30) days of return of this Agreement to Molina.

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Welcome to Molina Healthcare!

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

We're providing you this 2023 Molina of Washington Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

- How you can get Covered Services through Molina
  - Getting an interpreter
  - Choosing a Primary Care Provider (PCP)
  - Making an appointment
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Molina Member
  - Checking on Prior Authorization status
- How to contact Molina

Please read this Agreement carefully. Inside is information about a wide range of health needs and services provided. For questions or concerns, please reach out to Customer Support at MolinaMarketplace.com or (888) 858-3492.

We look forward to serving you!

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 explained in this "Definitions" section.

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

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

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

- *Emergency Services received from a Non-Participating Provider:*
  - At a hospital: Until July 1, 2023 (or a later date determined by the WA OIC), unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area.
  - At a hospital: On or after July 1, 2023, the Allowed Amount shall be the lesser of the Provider's charged amount and the qualifying payment amount, as defined by federal law.
  - At a freestanding emergency department: The Allowed Amount shall be the lesser of the Provider's charged amount and the qualifying payment amount, as defined by federal law.

- *Behavioral Health Emergency Services*: The Allowed Amount shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area.

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

- *All other Covered Services received from a Non-Participating Provider will be paid at the lesser of the following if all other terms of this Agreement are followed:*
  - Molina's median contracted rate for such service(s);
  - 100% of the published Medicare rate for such service(s); or
  - A negotiated amount agreed to by the Non-Participating Provider and Molina.

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

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

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

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

Balance Bill or Balance Billing: When a Provider bills a Member for the difference between the Provider's charged amount and the Allowed Amount. A Molina Participating Provider may not Balance Bill a Member for Covered Services. State and federal law prohibits Non-Participating Providers from Balance Billing for certain services, such as Emergency Services, Emergency Air Ambulance Transportation Services, and Behavioral Health Emergency Services.

Behavioral Health Emergency Services: Behavioral health emergency services means:

1) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition.
2) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider or to stabilize the patient.
3) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening, and stabilization services have been furnished. Post Stabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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

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

Copayment: A fixed 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-Participating Providers, or the cost of non-Covered Services

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

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

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

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

Drug Formulary or Formulary: A list of 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: Medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition:

(a) 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,
(b) Serious impairment to bodily functions, or
(c) Serious dysfunction of any bodily organ or part.

Emergency Fill: A limited dispensed amount of a prescribed medication that allows time for the processing of a Prior Authorization request. Emergency Fill only applies to those circumstances where a Member presents at a contracted pharmacy with an immediate therapeutic need for a prescribed medication that requires a Prior Authorization.

Emergency Services: Emergency services means:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, and further medical
2) Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to Stabilize the patient.

3) Covered Services provided by staff or facilities of a hospital after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening, and stabilization services have been provided.

Essential Health Benefits or EHB: A set of ten (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 Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are experimental or investigational, Molina will consider whether the services are in general use in the medical community in the State of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven safe and efficacious.

Facility Fee: Any separate charge or billing by a facility in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

FDA: The United States Food and Drug Administration.

Gender Affirming Treatment: A service or product that a health care provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care.

Gender X: A gender that is not exclusively male or female, including, but not limited to, intersex, agender, amalgagender, androgynous, bigender, demigender, female-to-male, genderfluid, genderqueer, male-to-female, neutrois, nonbinary, pangender, third sex, transgender, transsexual, Two Spirit, and unspecified.

Health Benefit Exchange/Marketplace: A governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Washington buy qualified health plan coverage from insurance companies or health plans such as Molina. The Health Benefit Exchange 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 Health Benefit Exchange operating in the State of Washington, however it may be organized and run.

Health Care Benefit Managers: Molina contracts with Health Care Benefit Managers (HCBMs) to provides services to or acts on behalf of Molina. HCBMs directly or indirectly impact the determination or use of benefits for or patient access to health care services, drugs and supplies. HCBMs include, but are not limited to, specialized benefit types such as pharmacy, radiology, laboratory and mental health. The services of an HCBM also include:

- Prior authorization or preauthorization of benefits or care
- Certification of benefits or care
- Medical necessity determinations

- Utilization review
- Benefit determinations
- Claims processing and repricing for services and procedures
- Outcome management
- Provider credentialing and re-credentialing
- Payment or authorization of payment to providers and facilities for services or procedures
- Dispute resolution, grievances or appeals relating to determinations or utilization of benefits
- Provider network management
- Disease management

Members may visit the following website which identifies each health care benefit manager contracted with Molina and identifies the services provided by the health care benefit manager: MolinaMarketplace.com/HCBM

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

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

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

Molina Healthcare of Washington, Inc. Agreement and Individual Evidence of Coverage (“Agreement”): This document, which has information about coverage under this Plan.

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

Originating Site: The physical location of a patient receiving health care services through Telemedicine. This includes a:

- Hospital
- Rural health clinic
- Federally qualified health center
- Physician's or other health care provider's office
- Community mental health center
- Skilled Nursing Facility

- Home or any location determined by the individual receiving the service
- Renal dialysis center, except an independent renal dialysis center

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

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

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

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

Primary Care Doctor (also a "**Primary Care Physician**" and "**Personal Doctor**"): A Provider who has identified their primary professional designation to Molina as a Primary Care Provider and is the physician who takes care of a Member's health care needs. A Primary Care Doctor has access to the Member's medical history. A Primary Care Doctor makes sure Member's get needed health care services. A Primary Care Doctor may refer Members to a Specialist for other services. A Primary Care Doctor includes, but is not limited to, one of the following types of doctors:

- Family or general practice doctor who usually can see the whole family
- Internal medicine doctor, who usually only see adults and children 14 years or older
- Pediatrician, who see children from newborn to age 18 or 21
- Obstetricians and gynecologists (OB/GYNs).

Primary Care Provider (PCP): A Provider who qualifies as a:

- Primary Care Doctor
- An individual practice association (IPA) or group of licensed doctors who have identified their primary professional designation to Molina as primary care
- Other Practitioner who within the scope of their license is authorized to provider primary care

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

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

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

Service Area: The geographic area where Molina has been authorized by the State of Washington 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. The Service Area consists of Benton, Clark, Cowlitz, Ferry, Franklin, King, Kitsap, Klickitat, Lewis, Lincoln, Mason, Pend Oreille, Pierce, Skamania, Snohomish, Spokane, Stevens, and Thurston counties in the State of Washington.

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).

Summary of Benefits and Coverage: A summary of Covered Services and applicable Member Cost Sharing. For a comprehensive list of applicable Cost Shares, please refer to the Schedule of Benefits.

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

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

Substance Use Disorder: Substance-related or addictive disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

Telehealth Services: Delivery of Covered Services by a Participating Provider through audio and video conferencing technology that permits communication between a Member at an Originating Site and a Participating Provider at a Distant Site, allowing for the diagnosis or treatment of Covered Services. Also, the communication does not involve in-person contact between the Member and a Participating Provider. During the virtual visit the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider. Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member's medical information through telecommunications without live interaction. to be reviewed at a later time. Store and Forward technology is an asynchronous transmission of a Member’s medical information from an Originating Site to the health care provider at a Distant Site which results in medical diagnosis and management of the Member and does not include the use of audio-only telephone, facsimile, or email. Applicable Cost Sharing for Covered Services delivered through Telehealth Services will be charged at either the Primary Care or Specialist care Cost Sharing, depending on the Provider type. Please note: Molina offers access to Telehealth Services to Members through Molina’s contracted Telehealth Services provider, Teladoc. Services through Teladoc are provided at no cost to Members. For more information regarding Teladoc services, please refer to MolinaMarketplace.com or contact Customer Support.

Telemedicine: The delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site

and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine includes audio-only Telemedicine but does not include facsimile or email.

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.

Withdrawal Management Services: Twenty-four (24) hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Women's Health Care Services: Organized services to provide health care to Members, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as Medically Necessary, and Medically Necessary follow-up visits for these services.

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 Health Benefit Exchange. 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 Health Benefit Exchange will set a yearly period in which eligible individuals can submit an application and enroll in a health insurance plan for the following year. The Effective Date of coverage will be determined by the Health Benefit Exchange.

Special Enrollment Period: A Qualified Individual has 60 days to report a qualifying event to the Exchange and could be granted a 60-day Special Enrollment Period as a result of one of the following events:

- A Qualified Individual or dependent loses minimum essential coverage
- Loss of dependent coverage due to the death of a Qualified Individual
- Loss of Essential Minimum Coverage due to a Reduction in employment hours
- Loss of Essential Minimum Coverage due to the termination of a domestic partnership
- A Qualified Individual loses employer sponsored coverage for any reason except for misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage
- A Qualified Individual experiences the loss of eligibility for Medicaid or a public program providing health benefits
- A Qualified Individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, or placement for adoption
- A Qualified Individual loses of coverage as the result of dissolution of marriage
- A Qualified Individual experiences a permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new Service Area or results in new eligibility for previously unavailable Qualified Health Plans
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the Qualified Individual
- Coverage is discontinued in a Qualified Health Plan by the Exchange pursuant to 45 C.F.R. 155.430 and the three-month grace period for continuation of coverage has expired
- Exhaustion of COBRA coverage due to failure of the employer to remit premium
- Loss of COBRA coverage where the qualified individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available
- A Qualified Individual discontinues coverage under a health plan offered pursuant to the Washington State Health Insurance Coverage Access Act
- A Qualified Individual loses coverage as a dependent on a group plan due to age
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan, or change from one Qualified Health Plan to another one time per month, without requiring an additional special enrollment triggering event
- A Qualified Individual lost prior coverage due to errors by the Exchange staff or the U.S. Department of Health and Human Services
- An individual, or his or her Dependent, who was not previously a citizen, national, or lawfully present individual gains such status

- An enrollee demonstrates to the Exchange that the Qualified Health Plan in which he or she is enrolled violated a material provision of its Contract in relation to the enrollee
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for Cost-Sharing Reductions, or the individual's dependent becomes newly eligible; or
- The individual or their dependent who is currently enrolled in employer sponsored coverage is determined to be newly eligible for Advanced Premium Tax Credits

If the enrollee eligible for the Special Enrollment Period had prior coverage, they will be offered the benefit packages available to individuals who enrolled during the open enrollment period within the same metal tier or level at which the enrollee had previously. Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. An eligible enrollee will not be required to pay more for coverage than a similarly situated individual who enrolls during open enrollment. An enrollee who was enrolled in a catastrophic plan as defined in RCW 48.43.005(8) may be limited to the plans available during open enrollment at either the bronze or silver level. An enrollee whose eligibility is based on their status as a dependent may be limited to the same metal tier for the plan on which the primary Subscriber is enrolled.

Molina may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event. This section should not be interpreted to limit the Exchange's rights to automatically enroll qualified individuals based on good cause or exceptional circumstances as defined by the Exchange or as required by the U.S. Department of Health and Human Services. Qualified Individuals that enroll between the first and twenty third day of the month will have a coverage Effective Date of the first day of the following month. Qualified Individuals that enroll between the twenty fourth and last day of the month will have a coverage Effective Date of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but advance payments of the premium tax credit and Cost-Sharing Reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, the beginning of a domestic partnership, or in the case where the Qualified Individual loses minimum essential coverage, the Effective Date is the first day of the following month. American Indians/Alaskan Natives eligible for services through an Indian Health Care Provider may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month. Please contact the Exchange for more information.

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 eighteen (18). For more information regarding eligibility and enrollment, please contact the Health Benefit Exchange.

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

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

Child or Children: The Subscriber's son, daughter, adopted child, stepchild, foster child or a descendent of any of them such as a Member's grandchild. Each child is eligible to apply for enrollment as a Dependent until the age of twenty-six (26).

Child with a Disability: A Child who reaches the age of twenty-six (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 of any age 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: A domestic partner of the Subscriber may enroll in this Plan. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Health Benefit Exchange and State Law.

Adding New Dependents: An individual may become eligible to be a Dependent after the Subscriber becomes enrolled in this Plan. The eligible individual may be able to enroll as a Dependent in the Member's Plan. Members must contact the Health Benefit Exchange 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 Health Benefit Exchange within 60 days from the date the Dependent became eligible to enroll in the Plan.

Spouse: A Spouse may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:

- Loss of minimum essential coverage, as defined by the Affordable Care Act
- The date of marriage to the Subscriber
- The Spouse gains status as a citizen, national, or lawfully present individual
- The Spouse permanently moves into the Service Area

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

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

Newborn Child: A newborn Child of a Subscriber is eligible as a Dependent at birth. A newborn is initially covered for thirty-one (31) days, including the date of birth. A newborn Child is eligible to continue enrollment if they enrolled with Molina within sixty (60) days of birth or adoption for enrollment.

Please note: Claims for newborn Children for eligible Covered Services will be processed as part of the mother's claims and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and Annual Out-of-Pocket Maximum. However, if an enrollment file is received for the newborn during the first thirty-one (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 Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or Annual Out-of-Pocket Maximum (i.e. not under the enrolled mother's Deductible and Annual Out-of-Pocket Maximum).

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

- At 11:59 p.m. Pacific time on the last day of the calendar month that the Dependent child attains age twenty-six (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 between the Subscriber and Dependent Spouse is entered.
- The date the termination of the domestic partnership decree between the Subscriber and Dependent Domestic Partner is entered.
- For Child-Only Coverage, at 11:59 p.m. Pacific time on the last day of the calendar month in which the Child Member reaches the limiting age of 21. Any Dependent may be eligible to enroll in other products offered by Molina through the Health Benefit Exchange.
- Date the Subscriber loses coverage under this Plan.

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

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

Member Right to Obtain Healthcare Services Outside of Agreement: Molina does not restrict Members from freely contracting at any time to obtain any healthcare services outside this Agreement on any terms or conditions they may choose. Members will be 100% responsible for payment for such services, and the payments for such services will not apply to their Deductible or Annual Out-of-Pocket Maximum under this Agreement. For exceptions, Members should review the "Emergency Services" and "No Participating Provider to Provide a Covered Service" sections of this 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 Customer Support.

Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP.

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

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

If a Member's Provider (PCP or Specialist) or a hospital where they are receiving treatment is no longer a Participating Provider, Molina will send the Member a letter to let them know. The letter will explain how the change affects the Member. If a PCP is no longer with Molina, the Member can choose a different PCP. Customer Support can help the Member select a new PCP.

Members who are assigned to a PCP or are receiving services from a hospital whose contract with Molina is terminating will receive written notice that the contract between Molina and the PCP or hospital is ending.

Telehealth Services and Telemedicine: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation.

Covered Services are also available through Telehealth, except as specifically stated in this Agreement. In-person contact with a Provider is not required for these services, and the type of setting where these services are provided is not limited. The following additional provisions apply to the use of Telehealth services:

- Must be obtained from a Participating Provider
- Are meant to be used when care is needed now for non-emergency medical issues
- Are a method of accessing Covered Services, and not a separate benefit
- Are not permitted when the Member and Participating Provider are in the same physical location
- Do not include texting, facsimile or e-mail only

Covered Services provided through store and forward technology must include an in-person office visit to determine diagnosis or treatment. Please refer to the "Definition" section for explanation.

Molina covers audio-only Telemedicine for a Member who has an established relationship with a provider rendering Covered Services. Established relationship means the Member has had at least one in-person appointment within the past year with the provider providing audio-only Telemedicine or with a provider employed at the same clinic as the provider providing audio-only Telemedicine or the covered person was referred to the provider providing audio-only Telemedicine by another provider who has had at least one in-person appointment with the

Member within the past year and has provided relevant medical information to the provider providing audio-only Telemedicine.

Moral Objections: Some Participating Providers may object to provide some of the services that may be 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 Participating Providers or Molina Customer Support to make sure they can get the healthcare services that they are seeking. Molina will assist Members to receive requested Covered Services rendered by other Participating Providers.

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. In most cases the Member shall pay no more than the same Cost Sharing that the Member would pay for the same Covered Services received from a Participating Provider, and the Non-Participating may not Balance Bill the member. For some items and services, if the Member consents to waive Balance Billing protections according to the required process under federal law, the Non-Participating Provider may Balance Bill the member. However, Non-Participating Providers may never Balance Bill the member for the following types of items services provided in a Participating Facility, even if the Member consents to waive Balance Billing protections:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

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

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

An Active Course of Treatment is:

- An ongoing course of treatment for a life-threatening condition, which is a

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

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

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

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.

ACCESS TO CARE

For an Emergency, call 911. For an Emergency, Members may call an Ambulance or go to any hospital emergency room, even if it is a Non-Participating Provider or outside of the Service Area.
24-Hour Nurse Advice Line: Registered Nurses are available twenty-four (24) hours a day year-round to answer questions and help Members access care. The Nurse Advice Line phone number is 1-888-275-8750.

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

- Emergency Services and Behavioral Health Emergency Services
- Services from a Non-Participating Provider that are subject to Prior Authorization
- Exceptions described below under "Non-Participating Provider at a Participating Provider Facility"
- Exceptions described below under "No Participating Provider to Provide a Covered Service"
- Exceptions described under "Continuity of Care" section
- Exceptions described under "Transition of Care" section

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

Appointment Type for PCPs	When a Member should get the appointment
Emergency care	Available 24 hours / 7 days
Urgent Care	Within 48 hours of the appointment request
Preventive care – non-urgent	Within 30 calendar days of request
Routine or non-Urgent Care	Within 10 calendar days of request
After-hours care	Available 24 hours / 7 days
Office waiting time	Should not exceed 30 minutes

PRIOR AUTHORIZATION

Emergency Medical Conditions: Emergencies do not require Prior Authorization.

Prior Authorization Process: Some services and prescription drugs must be approved by Molina before they will be covered for a Member. This process is called Prior Authorization. If a service requires Prior Authorization, a Provider will request authorization from Molina on behalf of the Member. If authorization for a service is not provided by Molina, a Member may appeal the decision. To find out if a service requires Prior Authorization, please contact Customer Support. For a complete list of covered medications, please review the Molina formulary at MolinaMarketplace.com. The following services always require authorization:

- Hospital stay (non-emergency). *This does not apply to inpatient or residential Substance Use Disorder treatment services in a behavioral health facility*.
- Long-Term Care (nursing home or long-term facility)
- Durable Medical Equipment
- Non-Emergency Surgery

Prior Authorization is not required for an initial evaluation and six (6) treatment visits for outpatient speech therapy, occupational therapy, physical therapy, chiropractic services, massage therapy, hearing therapy, eastern medicine, or acupuncture services for each new episode of care. New episode of care means treatment for a new condition or diagnosis for which the Member has not been treated by a provider of the same licensed profession within the previous ninety days and is not currently undergoing any active treatment.

Authorization Decision Timeframes

Medical Services:

- **Routine Prior Authorization Requests:** Will be processed within five (5) calendar days from receipt of all information reasonably necessary and requested by Molina to make the determination
- **Expedited Prior Authorization requests:** For medical conditions (that are not Emergency Medical Conditions) that a Member's provider believes may cause a serious threat to a Member's health, authorizations are processed within two (2) calendar days from receipt of all information reasonably necessary and requested by Molina to make the determination.

If additional information is needed to make the Prior Authorization determination, Molina will approve or deny the request within four (4) calendar days of the receipt of the additional information. Molina would deny a Prior Authorization if information requested is not provided. Expedited Prior Authorization requests related to medical conditions that may cause a serious threat to a Member's health are processed within two (2) calendar days. This is two (2) calendar days from when Molina receives the information needed to make the decision. In the event that the expedited Prior Authorization request is also a concurrent review request, Molina will make a determination as soon as possible and no later than twenty-four (24) hours after receipt, provided that the Prior Authorization request is made at least twenty-four (24) hours prior to the expiration of the previously approved period of time or number of treatments. For post-service review requests, Molina will make its determination within thirty calendar days. Molina will deny

a Prior Authorization if information Molina has requested is not provided within the required timeframe.

Prescription Drugs and Medications: Prior Authorization decisions and notifications for medications not listed on the Molina formulary will be provided as described in the section of this Agreement titled “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, they may visit MolinaMarketplace.com or contact Customer Support at the number shown in the Reference Guide on page 2 of this Agreement. Molina can explain how Medical Necessity decisions are made.

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 a letter telling them why a 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 tell Members how to appeal. These instructions are in the section of this Agreement titled “Grievances and Appeals.”

If a Member or their Provider decides to proceed with a service that has not been approved, the Member will have to pay the cost of those services as “non-covered” services not covered by this Agreement

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

Inpatient Concurrent Review: Molina conducts concurrent review on inpatient cases. For non-Emergency admissions, a Member, their Provider, or the admitting facility will need to request precertification at least fourteen (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 twenty-four (24) hours or as soon as reasonably possible after the Member has been admitted. For outpatient and inpatient non-Emergency medical services requiring Prior Authorization, a Member, their Provider, or the admitting facility must notify Molina at least fourteen (14) days before the outpatient care is provided, or the procedure is scheduled. For inpatient acute care, Molina will coordinate services within forty-eight (48) hours and will continue to follow up every forty-eight (48) hours.

Second Opinion: A Member or their 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.

Emergency Services and Behavioral Health Emergency Services: Emergency Services and Behavioral Health Emergency Services are available twenty-four (24) hours a day, seven (7) days a week for Molina Members. Members who think they are having an Emergency should:

- Call 911 right away.
- Go to the closest hospital or emergency room.

When getting Emergency Services or Behavioral Health Emergency Services, Members should bring their Member ID card.

Members who are not sure if they need Emergency Services or Behavioral Health Emergency Services but who need medical help should call their PCP or call the 24-Hour Nurse Advice Line toll-free.

Please do not go to a hospital emergency room if the condition is not an Emergency.

Emergency Services When Out of the Molina Service Area: Go to the nearest Emergency room for care. Please contact Customer Support within twenty-four (24) hours or as soon as possible.

Urgent Care Services and After-Hours Care: Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury. Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Members must get Urgent Care Services from a Participating Provider. 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 the Participating Provider Urgent Care center ahead of time.

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

Important: Except as otherwise required by State Law, when Emergency Services and Behavioral Health Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, claims will be paid at Molina's Allowed Amount. An Emergency Medical Provider in Washington may not Balance Bill Members for Emergency Services; and Molina will hold Members harmless for Balance Billing for Emergency Services, as well. Members are only responsible for the Cost Sharing shown in the Schedule of Benefits for such Emergency Services.

Transfer to a Participating Provider Hospital: Prior Authorization is required to receive Hospital services, except in the case of Emergency Services and Behavioral Health Emergency Services. For Members who are admitted to a Non-Participating Provider hospital for Emergency Services or Behavioral Health 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 coverage terminates during a hospital stay, the services received after the termination date are not Covered Services.

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

Emergency Ground Ambulance Medical Transportation: Emergency ground ambulance medical transportation, or ground 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. Covered Ground Ambulance Emergency Transportation Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing identified in the Schedule of Benefits. Non-Participating Providers of Emergency Ground Ambulance Medical Transportation may Balance Bill for non-covered charges.

Emergency Air Ambulance Medical Transportation: Emergency air ambulance medical transportation services are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. Covered Air Ambulance Emergency Transportation Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing identified in the Schedule of Benefits. Non-Participating Providers of Emergency Air Ambulance Medical Transportation may not Balance Bill Members for non-covered charges.

Pregnancy and Maternity: Molina covers medical, surgical and hospital care during the term of pregnancy, which includes coverage for a Dependent's pregnancy. This includes prenatal, intrapartum, and perinatal care, upon delivery for normal delivery, spontaneous abortion (miscarriage), and Complications of Pregnancy.

Molina covers the following maternity care services related to labor and delivery:

- Inpatient hospital care and birthing center care, including care from a certified nurse midwife, for forty-eight (48) hours after a normal vaginal delivery. It also includes care for ninety-six (96) hours following a delivery by cesarean section (C-section). Longer stays need to be authorized by Molina. Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Schedule of Benefits for the Cost Sharing that will apply to these services.
- If the Member's Provider, after consulting the Member, decides to discharge the Member and their newborn before the forty-eight (48) or ninety-six (96) hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the Member or their newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the Member. If the hospitalization period is shortened, then at least three (3) home care visits will be covered. The Member and their Provider may agree that one (1) or two (2) visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. Please note,

Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable. Also, laboratory tests Cost Sharing will apply to laboratory services).
- Nursery services and supplies for newborns, including newly adopted children
- If a Member is a medically high-risk pregnant individual about to deliver a baby, Molina will cover transportation, including air transport, to the nearest appropriate health care facility when necessary to protect the life of the newborn or the Member.
- Prenatal diagnosis of congenital disorders by screening and/or diagnostic procedures if medically necessary.

Phenylketonuria (PKU) and other Inborn Errors of Metabolism: Molina covers testing and treatment of phenylketonuria (PKU). Molina also covers other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. The health care professional will consult with a Provider who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. For purposes of this section, the following definitions apply:
- Formula is an enteral product for use at home that is prescribed by a Participating Provider.
- Special Food Product is a food product that is prescribed by a Participating Provider for treatment of PKU. It may also be prescribed for other inborn errors of metabolism. It is used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.
- Other specialized formulas and nutritional supplements are not covered. (Prescription Drug Cost Sharing will apply)
- Elemental formula for eosinophilic gastrointestinal associated disorder

Molina covers Medically Necessary elemental formula, regardless of delivery method, when associated to eosinophilic gastrointestinal associated disorder. This benefit must be order and supervised by a Participating Provider, outpatient professional services Cost Share applies.

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 Molina Customer Support to request reasonable accommodation assistance

Physical Access: Every effort has been made to ensure that Molina's offices and the offices of Participating Providers are accessible to persons with disabilities. Members with special needs should call Molina's Customer Support at the number shown in the Reference Guide on page 2 in this Agreement for assistance finding an appropriate Participating Provider.

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

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important Member 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 Molina Customer Support.

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

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. Cost Sharing will not be more than the actual charge for the service, drug, or medical equipment.

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.

Members who receive Covered Services at an outpatient hospital-based clinic (both on and off campus outpatient hospital) may be subject to both an facility fee and professional fee Cost Sharing. An outpatient hospital-based clinic is a portion of an outpatient hospital provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Members should refer to their Schedule of Benefits for 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 ten (10) categories of benefits identified in the ACA and its corresponding federal regulations. Members cannot be excluded from coverage in any of the ten (10) EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. Pacific time on the last day of the month that they turn age nineteen (19). This includes pediatric dental coverage that can be purchased separately through the Health Benefit Exchange and pediatric vision coverage.

Under the ACA and its corresponding federal regulations governing EHBs:

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

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

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.

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 evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). These recommendations include pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection. Please visit the USPSTF website for preventive services recommendations at: https://www.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 state regulation and HRSA for women's preventive and wellness service guidelines to the extent not already included in certain recommendations of the USPSTF.
- Screening for physical, mental, sexual, and reproductive health care needs that arise from sexual assault, regardless of the member's gender.

Molina provides coverage for contraceptive services, including emergency contraception, vasectomy, insertion/extraction of contraceptive devices, prescription-based sterilization procedures for women and tubal ligation. Coverage is not provided for the reversal of sterilization procedures.

Molina covers obesity screening and counseling, including offering or referring Members age six (6) and older who have a body mass index (BMI) of 30 kg/m2 or higher, or have additional cardiovascular disease (CVD) risk factors, to intensive multicomponent behavioral interventions to promote a healthful diet and physical activity for CVD prevention.

Molina covers counseling for women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.

Coverage is provided for breastfeeding support, supplies, counseling and includes the purchase of personal-use electric breast pump, one pump per birth. In the event of multiple births, only one pump is covered. Coverage of breastfeeding equipment includes double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. This coverage includes the necessary supplies for the pump to operate.

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 and its corresponding federal regulations and applicable State Law.

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

- Office visits, including:
  - Associated medical supplies
  - Prenatal and postnatal visits
- Chemotherapy and other Provider-administered drugs administered in a physician's office, an outpatient, or an inpatient setting. These services are subject to either outpatient facility or inpatient facility Cost Sharing.
- Diagnostic procedures, including:
  - Colonoscopies
  - Cardiovascular testing
  - Pulmonary function studies
  - Neurology/neuromuscular procedures
- Radiation therapy (Members may be subject to facility and professional Cost Sharing based on the place of service)
- Routine pediatric and adult health exams
- Therapeutic injections and related supplies
- 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 (Prior Authorization is required. Separate facility Cost Sharing may apply).

Habilitation Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 days): 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, occupational therapy, aural therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Molina covers Medically Necessary neurodevelopmental therapy. Services are limited to a combined 25 visits per calendar year (This limitation does not apply to Covered Services for autism spectrum disorders).

Rehabilitation Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 days): 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-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Massage therapy is covered when provided as part of physical therapy and/or chiropractic care in connection with rehabilitation and/or habilitation services. Eligible providers include contracted physical therapists, chiropractors, naturopathic providers and massage therapists or any other

provider acting within the scope of their licensure. All services provided during the same session count as one visit. Members have direct access to a chiropractor without referral.

Rehabilitation services are limited to 25 combined speech, physical, and occupational visits per calendar year, however, there is no limit when Medically Necessary services are received due to a Mental Health condition or Substance Use Disorder. Spinal manipulation services are limited to 10 treatments per year. Acupuncture services are limited to 12 visits without referral per calendar year. Acupuncture services provided for the treatment of chemical dependency are not subject to any visit limits.

Dental and Orthodontic Services: Dental and orthodontic services provided under this agreement are limited to the following, which must be Prior Authorized:

- Dental services for radiation treatment
- Dental anesthesia for those who would be at risk if the service were performed elsewhere and without anesthesia
- Dental and orthodontic services for cleft palate
- Services to treat Temporomandibular Joint Syndrome (TMJ) (Please refer to the Temporomandibular Joint Syndrome section of this Agreement)
- Services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease
- Oral surgery needed due to trauma or injury

Molina does not provide pediatric dental services under this Agreement.

Temporomandibular Joint Syndrome ("TMJ"): Molina covers the following services to treat temporomandibular joint syndrome (also known as "TMJ")

- Medically Necessary medical non-surgical treatment (e.g., splint and physical therapy) of TMJ
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed

For Covered Services related to dental or orthodontic care in the above sections, Members will pay the Cost Sharing they would pay if the services were not related to dental or orthodontic care. For example, see "Inpatient Hospital/ Facility Services" in the Schedule of Benefits for the Cost Sharing that applies for hospital inpatient care.

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

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

- Preventive Services including:
- Diabetes education and self-management
- Diabetes (Type 2) screening
- Screening for gestational diabetes
- Dietician services
- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Podiatric devices to prevent or treat diabetes related foot problems
- Visual aids, excluding eyewear, to assist those with low vision with proper dosing of insulin

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

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

- Routine vision screening and comprehensive eye exam which includes dilation as professionally indicated and with refraction every Plan year
- Prescription glasses: frames and lenses, limited to one (1) pair of prescription glasses once every twelve (12) months
- Covered frames include a limited selection of frames. Participating Providers will offer the limited selection of frames available to Members under this Agreement. Frames that are not within the limited selection of frames under this Agreement are not covered.
- Prescription lenses include single vision, lined bifocal, lined trifocal, lenticular lenses, and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.
- Prescription contact lenses: In lieu of prescription lenses and frames, Molina covers prescription contact lenses limited to one (1) year supply every twelve (12) months. This includes evaluation, fitting, and follow-up care. Also covered in lieu of prescription lenses and frames, are prescription contact lenses for the treatment of:
    - Aniridia
    - Aniseikonia
    - Anisometropia
    - Aphakia
    - Corneal disorders
    - Irregular astigmatism
    - Keratoconus
    - Pathological myopia
    - Post-traumatic disorders
- 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 Authorization is obtained. Coverage includes, with Prior Authorization:
    - One comprehensive low vision evaluation every five (5) years
    - High-power spectacles, magnifiers, and telescopes as Medically Necessary; and
    - Follow-up care

Please note: laser corrective surgery is not covered.

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

- Diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated

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

Pregnancy Termination: Molina covers pregnancy termination services as required by the Affordable Care Act and by any applicable laws in the State of Washington. Pregnancy termination services are office-based procedures and do not require Prior Authorization. If pregnancy termination services will be provided in an inpatient setting or outpatient hospital Prior Authorization is required. Please refer to the Schedule of Benefits for applicable Member Cost Sharing.

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 MRIs with Prior Authorization. Molina can assist Members select an appropriate facility for these services. Limited coverage for Medically Necessary dental and orthodontic X-rays is outlined in the Dental and Orthodontic Services section of this Agreement. Molina covers laboratory tests to assist Members in deciding what birth control method to use. Molina covers blood, blood products, and blood storage, including the services and supplies of a blood bank.

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered hospital services, except in the case of Emergency Services and Behavioral Health Emergency Services. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services or Behavioral Health Emergency Services, will be covered without Prior Authorization, provided the Member's coverage with Molina has not terminated and the services are otherwise Covered Services. Molina may 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.

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.

Gender Affirming Treatment: Molina covers Gender Affirming Treatment which is Medically Necessary and prescribed in accordance with the accepted standards of care.

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 includes professional services, anesthesia, surgical supplies. These services may be provided in any of the following outpatient locations:

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

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

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. Involuntary admissions do not require Prior Authorization.

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

Molina covers the following outpatient mental health services when provided by Participating Providers who are physicians or Other Practitioners acting within the scope of their license and qualified to treat mental illness:

- Individual, family and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder (defined below)
- Outpatient services for the purpose of monitoring drug therapy
- Court ordered medically necessary mental health treatment
- Services provided pursuant to involuntary commitment proceedings
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations
- Mental health treatment for diagnostic codes F65.0 through F65.4, F65.50 through F65,52, F65.81, F65.89, F65.9 and F66 in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or for "V code" diagnoses including medically necessary services for parent-child relational problems for children five years

of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria consistent with Washington state law.

Molina covers behavioral health Emergency Services in a crisis stabilization, an evaluation and treatment licensed facility that can provide emergency evaluation and treatment, an outpatient crisis services, or Withdrawal Management Services agency certified by the State, a triage facility, or mobile rapid response crisis team. Inpatient and outpatient mental health services do not include therapy or counseling for career, marriage, divorce, parental or job. Molina does not cover services for conditions that the DSM identifies as something other than a Mental Disorder.

Molina covers Mental Health Services delivered in various settings, including:

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

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 management services. Molina also provides coverage for substance use disorder treatment in a nonmedical transitional residential recovery setting when Prior Authorized. Molina covers the following outpatient care for treatment of Substance Use Disorder:

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

Substance Use Disorder treatment is covered in a non-medical transitional residential recovery setting when approved in writing by Molina. These settings provide counseling and support services in a structured environment. Non-medical residential services do not include therapy or counseling for any of the following: career, marriage, divorce, parental, behavioral, job, treatment or testing related to autistic spectrum disorder, learning disabilities, and mental disability.

Prior Authorization is not required for admission to a licensed/certified behavioral health facility that provides inpatient or residential substance use disorder treatment services. However, this does not negate the facility's duty for admission notification (must occur within twenty-four (24) hours), and timely presentation of the initial assessment and treatment plan. Molina will conduct a utilization review for medical necessity on a continued stay after three (3) days in a behavioral health facility that is providing withdrawal management services, or two (2) business days

(excluding weekends and holidays) in a behavioral health facility that is providing Substance Use Disorder treatment services.

If the behavioral health facility is not in Molina's Provider network (but is in the State of Washington), Molina will reimburse the Non-Participating Provider facility at Molina's Participating Provider rate for such services, under the timeframes noted above. Treatment provided in out-of-state facilities must still undergo Prior Authorization. Note: the non-participating behavioral health providers, if one is used, may not Balance Bill the Member.

Skilled Nursing Facility: Molina covers sixty (60) days per Plan year in 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

Hospice Services (Fourteen (14) day limit): Molina covers hospice services for Members who are terminally ill (a life expectancy of 12 months or less). Members can choose hospice care instead of the traditional services covered by this Plan. Molina covers home hospice services and a semi-private room in a hospice facility. Molina also covers respite care up to 14 days per lifetime, which can be delivered on an inpatient basis in a hospital or skilled nursing facility.

Long-Term Care (Following Hospitalization): Molina covers up to 60 days of Medically Necessary care at a Long-Term Care Facility following hospitalization if the Member resided in that Long-Term Care Facility immediately prior to the hospitalization, and all of the following are met:

- The Member's Primary Care Provider determines that medical care needs can be met at the requested Facility. The requested Facility has all applicable licenses and certifications and is not under a stop placement order that prevents the Member's readmission.

- The requested Facility agrees to accept payment for Covered Services at the rate Molina pays to similar Facilities that are Participating Providers

- The requested Facility agrees to abide by the standards, terms, and conditions Molina requires for similar Facilities that are Participating Providers for (i) utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting

A "Long-Term Care Facility" or "Facility" for the purpose of this benefit is a nursing facility licensed under Chapter 18.51 of the Revised Code of Washington, a continuing care retirement community defined under Section 70.38.025 of the Revised Code of Washington, or an assisted living facility licensed under Chapter 18.20 of the Revised Code of Washington.

The Member or their authorized representative must obtain Prior Authorization for these services. Inpatient hospital/Facility Services Coinsurance Cost Share will apply.

Alternative to Hospitalization or Inpatient Care: To the extent mandated by State Law, home healthcare furnished by duly licensed home health, hospice and home care agencies (including

skilled nursing care) covered by this Agreement may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home healthcare:

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

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

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 Molina Customer Support for further information.

Autism Spectrum Disorder Services: 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.

Cancer Treatment: Molina provides the following coverages for cancer prevention, screening, 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).
- Mammogram services, both diagnostic and screening
- Colorectal screening for all adults age of forty-five (45) and older or colorectal screening for Members less than fifty (50) years old and at high risk or very high risk for colorectal cancer. Molina does not impose Cost Sharing for the following services that are integral to performing the colonoscopy:
    - Required specialist consultation prior to the screening procedure;
    - Bowel preparation medications prescribed for the screening procedure;
    - Anesthesia services performed in connection with a preventive colonoscopy;
    - Polyp removal performed during the screening procedure; and
    - Any pathology exam on a polyp biopsy performed as part of the screening procedure; or
    - A colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)

- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more information)
- Biomarker testing services, when prescribed by a Participating Provider, are not subject to Prior Authorization requirements for Members with stage 3 or 4 cancer or for Members with recurrent, relapsed, refractory, or metastatic cancer.

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

Transplant Services: Molina covers transplants of organs, including artificial organs, tissue, or bone marrow, with no waiting period, at Participating Provider facilities when Prior Authorized. If a Participating Provider determines that a Member does not satisfy its respective criteria for a transplant, Molina will only cover services the Member received before that determination is made. Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor. In accordance with Molina guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor, or an individual identified as a potential donor, regardless of whether the donor is a Member. These services must be directly related to a covered transplant for the Member. Covered Services may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications. Members will be responsible for applicable professional and facility Cost Sharing for these Covered Services based on their Plan. Molina guidelines for donor services are available by calling Customer Support.

Limited transplant-related travel services can be reimbursed by Molina, subject to Prior Authorization. Coverage for Members who must travel more than sixty (60) miles from their residence to receive covered transplant services will include a per diem cap for lodging with a mileage reimbursement at the Internal Revenue Service (IRS) rate for medical mileage. Members should contact Customer Support for questions regarding coverage. No Cost Sharing applies to these identified covered limited transplant-related travel services.

Molina provides or pays for donation-related services for actual or potential donors (whether or not they are Members) in accord with Molina guidelines for donor services at no charge.

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

Women's Health Care Services: In accordance with State Law, Molina covers Medically Necessary Women's Health Care Services for all Members, including maternity care, reproductive health services, gynecological care, general examination, and preventive service visits for these services from Providers practicing within the lawful scope of practice. For reference, Providers practicing within the lawful scope of practice for these services may include, but not limited to, Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), physician assistants, midwives, advanced registered nurse practitioner specialists. Molina does not exclude or limit access to covered Women's Health Care Services offered by a particular type of women's health care Participating Provider or contracted facility in a manner that would unreasonably restrict access to that type of Participating Provider, contracted facility, or Covered Service.

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. 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 Member and Provider if the request is either approved or denied based upon Medical Necessity review.

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

Molina 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, prospective enrollees, the State, the Exchange, HHS and the U.S. Office of Personnel Management, and the general public on MolinaMarketplace.com/WAFormulary2023. A hardcopy is also available upon request. The list of products on the Formulary are chosen by a group of medical professionals from inside and outside of Molina. This group reviews the Formulary regularly and makes changes every three months based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs.

Access to Nonformulary Drugs: Molina has a process to allow Members to request coverage of clinically appropriate drugs that are not on the formulary or have "fail first" or other requirements that have not been met. Drugs that are not on the formulary may not be covered by the Plan and may cost Members more than similar drugs that are on the formulary if covered on "exception," as described in the next sections. Members may ask for nonformulary drugs to be covered by asking their provider to submit a formulary exception request. Requests for coverage of nonformulary drugs will be considered for a medically accepted use when Formulary options cannot be used, and other coverage requirements are met. An enrollee's response to drug samples from a provider or a drug maker will not be considered as a reason to bypass standard rules for plan drug coverage.

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 through the exceptions process to get from a pharmacy using the plan pharmacy benefit.

Requesting a Formulary Exception: The process for requesting a formulary exception is the same process for requesting Prior Authorization on formulary drugs that require advanced approval for coverage. Requests are reviewed against standard rules to determine Medical Necessity.

A provider may fax a completed **Prior Authorization/Medication Exception Request** form to Molina at 1 (800) 869-7791. The form may be obtained on our website MolinaMarketplace.com at the provider forms and documents page. The form fields must be completed to be accepted and the request must include all medical information for consideration.

A Member who is stabilized on a nonformulary drug may remain on the drug during the formulary exception review process by requesting an emergency fill. To request an emergency fill, the pharmacy can call 1 (800) 213-5525, Option 1-2-2. Trials of drug samples from a prescriber or a drug manufacturer will not be considered as current treatment.

Molina will grant a formulary exception if its reviewers determine the supporting information shows any of the following:

- The Member has a medical contraindication to formulary or required drug(s)
- The required drug(s) will likely cause a clinically predictable adverse reaction if taken by the Member
- The required drug is expected to be ineffective basted on the Member's documented clinical characteristics
- The Member has tried the required drug, a related drug, or a drug that works in a similar way, and discontinued it due to lack of effectiveness, loss of effect, or adverse event
- The Member is established on the drug as a current treatment with documentation of a positive therapeutic outcome and switching to the required drug will likely cause clinically predictable adverse reactions or harm
- The supporting medical information clearly shows formulary or required drugs are not in the member's best interest, because they are likely to:
    - Present a barrier to treatment plan adherence, or
    - Negatively impact a Member's comorbid condition, or
    - Cause a clinically predictable negative drug interaction, or
    - Decrease the Member's ability to achieve or maintain reasonable functional ability in performing daily activities

After receiving all the needed information from the member's provider to decide, Molina will notify the Member's treating provider of approval or denial of the request:

- Within 72 hours for standard requests, and
- Within 24 hours for urgent requests

Exception requests are considered urgent when a member is experiencing a health situation that may seriously jeopardize their life, health, ability to regain maximum function, or when a member is undergoing a current course of treatment using a nonformulary drug.

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. The prescriber may request to talk to Molina

reviewers about the denial reasons. If the member disagrees with the denial of the request, the ember can appeal Molina's coverage decision. The prescriber may also request that an Independent Review Organization (IRO) review Molina's coverage decision during an appeal. The IRO will notify the requesting prescriber of the IRO decision no later than:

- 72 hours following receipt of an appeal of a denied standard exception request
- 24 hours following receipt of an appeal on a denied urgent 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 Share 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 Non-Preferred Generic drugs; Higher cost sharing than lower tier drugs used to treat the same conditions.
Tier 4	All Specialty Drugs; Brand-Name and Generic; Higher cost sharing than lower tier drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use the network specialty pharmacy.
Tier 5	Nationally recognized preventative service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 Cost Sharing.
DME	Durable Medical Equipment ("DME") Cost Sharing applies; some non-drug products on the Formulary have Cost Sharing determined by the DME Coinsurance.

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

Third-Party Cost Sharing Assistance: Cost Sharing paid by the Member or on their behalf for a covered drug will apply as if the Member paid it and will count toward any applicable Deductible or yearly Out-of-Pocket Maximum under their plan. This includes Third-Party Cost Sharing Assistance. Third-Party Cost Sharing Assistance means discount cards, coupons, cash

or other financial help a Member may get from a company, a person, a charitable organization, or a sponsored program for the purpose of paying Cost Sharing on a drug Molina is covering for the Member. Amounts the Member pays or are paid on their behalf for a drug Molina does not cover or have denied coverage for will not apply.

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

Contraceptive Drugs and Devices: Molina provides coverage, with no Cost Sharing, and with no prescription required, for all FDA approved over-the-counter contraceptive drugs and devices, including condoms, regardless of the gender or sexual orientation of the covered person, regardless of whether they are used to be for contraception or exclusively for the prevention of sexually transmitted infections. Molina does not limit changes to a member's method of contraception.

In addition, Molina does not impose any waiting periods, or restrictions or delays, such as medical management techniques, that limit a Member's choice in accessing the full range of contraceptive drugs, devices or other products that have been approved by the FDA.

Coverage is provided for a 12-month refill of all FDA approved methods of contraception that are obtained at one time by the Member. Members are allowed to obtain contraceptive drugs on-site at the provider's office, if available.

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

Diabetic Supplies: Molina covers diabetic supplies on the Formulary such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, continuous glucose monitoring DME, blood glucose test strips, urine test strips, and select pen delivery systems for the administration of insulin. Member Cost Sharing for covered insulin medication is not subject to deductible and is limited to $35 per thirty-day supply of the medication.

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

Day Supply Limit: While Providers determine how much drug, product supply, or supplement to prescribe, Molina may only cover one month of supply at a time for certain products. The Formulary indicates "MAIL" for items that may be covered with a three-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.

In addition, Molina's pharmacy procedures will allow you, without consulting a physician, prescription, or refill from a physician, to provide for one early refill of a prescription for topical ophthalmic products if all of the following criteria are met:

(1) The refill is requested by a patient at or after seventy percent of the predicted days of use of:

(a) The date the original prescription was dispensed to the patient; or

(b) The date that the last refill of the prescription was dispensed to the patient;

(2) The prescriber indicates on the original prescription that a specific number of refills will be needed; and

(3) The refill does not exceed the number of refills that the prescriber indicated under subsection (2) of this section.

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

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs and their administration. Prior Authorization requests for drug's 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 usage outside of 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. All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication.

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

Mail Order Availability of Formulary Drugs: Molina offers Members a mail order option for certain drugs in tiers 1, 2, 3 and 5. Eligible drugs are marked "MAIL" on the Formulary. Formulary drugs will be mailed to a Member within 10 days of 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 (2.5) times the one-month supply Cost Share 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. Please 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

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

- Cosmetic drugs (This does not include drugs that may be necessary for gender affirming treatment)
- Hair loss or growth treatment
- Infertility (other than treating an underlying infertility cause itself)
- Erectile dysfunction
- Sexual dysfunction
- Gene therapy
- Homeopathic treatments and nutritional supplements
- Proposed less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Weight loss drugs

Emergency Fill: Emergency Fill is a short-term dispensed amount of medication that allows time for the processing of a Prior-Authorization request. Only the Emergency Fill dosage of the medication will be approved and paid.

Emergency Fills may be appropriate in circumstances where a Member presents at an in-network-pharmacy with an 'urgent therapeutic need' for a prescribed medication that requires a Prior Authorization due to Formulary or other utilization management restrictions. An in-network-pharmacy may do a one-time override to provide the Member with an Emergency Fill without a Prior Authorization if:

- In-network-pharmacy cannot reach the Molina's prior authorization department by phone because it is outside of Molina's business hours
- Molina is available to respond by phone to the dispensing pharmacy regarding benefit, but Molina cannot reach the Member's prescribing provider for full consultation
- A Member has an urgent therapeutic need; where a passage of time (i.e., the timeframe required for an Urgent Review) without treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the Member or others in contact with the Member.

The dosage of the Emergency Fill must either be the minimum packaging size that cannot be broken (e.g., injectable), or the lesser of a 7-day supply or the amount as prescribed. In the event the medication is to be continued for treatment beyond the Emergency Fill authorization, Molina may apply formulary or utilization management restrictions that will be reviewed following the Molina standard procedure.

Members will be responsible for a 30-day supply cost share. The Cost Share is based on the tier in which Molina has placed the drug. This may also include Deductibles, Coinsurance, Copayments, and similar charges. For Cost Share information please refer to the Schedule of Benefits.

PRESCRIPTION DRUG RIGHTS

Members have the right to safe and effective pharmacy services. Members also have the right to know what drugs are covered by their plan and the limits that apply. If Members have a question or concern about their prescription drug benefits, they may contact Us at 1-(888) 858-3492 or visit MolinaMarketplace.com. Molina's customer support staff are available Monday through Friday, 7:30 a.m. through 6:30 p.m. Pacific time. Members who are deaf or hard of hearing, may call 7-1-1 TTY for the deaf or hard of hearing or toll-free at (800) 735-2989.

Members who would like to know more about their rights, or if they have concerns about their plan, may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. Members who have a concern about the pharmacists or pharmacies serving them, please contact the Washington State Department of Health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov

Prosthetic, Orthotic, Internally Implanted and External Devices: Molina covers FDA approved prosthetic, orthotic, internally implanted and external devices. Prior Authorization is required. Some devices that are covered, but not limited to:

Internally implanted devices:
- Cochlear implants
- Hip joints
- Intraocular lenses
- Osseointegrated hearing devices
- Pacemakers

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

Coverage is dependent on all of the following requirements being met:

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

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

Molina does not cover foot orthotics, cranial banding, and some types of braces, including over-the-counter orthotic braces. However, braces that stabilize an injured body part and braces to treat curvature of the spine are covered.

Home Healthcare (up to 130 visits per year): Molina covers home healthcare services on a part-time, intermittent basis to a Member confined to his or her home due to physical illness when Prior Authorized and provided by a contracted home healthcare agency. Molina covers the following home healthcare services:

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

The following home health care services are covered under this Agreement:

- Up to two (2) hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four (4) hours per visit by a home health aide.
- Up to one-hundred and thirty 130 visits per calendar year (counting all home health visits)

Members must receive a Prior Authorization for home health services after seven (7) visits. Please refer to the "Exclusions" section of this Agreement for a description of benefit limitations and applicable exceptions.

Dialysis Services: Molina covers acute and chronic dialysis services, including in both home and outpatient settings, if all the following requirements are met:

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

Hearing Services:
Molina does not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section).
Molina does cover routine hearing screenings that are Preventive Care Services at no charge.

EXCLUSIONS

This section lists specific items and services excluded from coverage under this Agreement. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Covered Services" section.

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 unless a Participating Provider determines that the services are Medically Necessary.

- Physical exams and other services that are:
  - Required for obtaining or maintaining employment or participation in employee programs
  - Required for medical coverage, life insurance coverage or licensing, or
  - On court order or 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 medically necessary gender affirming treatment and 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 Service except for when covered under the nutritional counseling benefit or Hospice Care benefit. Please consult the Schedule of Benefits for additional details.

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

Experimental or Investigational Services: Any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in the medical community in the State of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

This exclusion does not apply to any of the following:

- Services covered under "Approved Clinical Trials" in the Covered Services section of this Agreement.

Please refer to the “External Review or Appeal” section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

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

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

Intermediate Care: Care in a licensed intermediate care facility is not covered. This exclusion does not apply to services covered under Durable Medical Equipment, Home Healthcare, Skilled Nursing Facility Care and Hospice Care in the Covered Services sections of this Agreement.

Non-Healthcare Items: Molina does not cover non-healthcare items, supplies, and equipment, including patient convenience items.

Non-Healthcare 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.

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

Oral Nutrition: Outpatient oral nutrition is not covered, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food. Please consult the Phenylketonuria (PKU) and other Inborn Errors of Metabolism section of this document for exceptions.

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

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

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

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

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

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

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

Surrogacy: Services for anyone in connection with a surrogacy arrangement are not covered, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy

arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

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

CLAIMS

Filing a Claim: Providers must promptly submit to Molina claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Molina and must include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Member or Provider to Molina within 365 calendar days after the following have occurred: 1). Discharge for inpatient services or the date of service for outpatient services; and 2) Provider has been furnished with the correct name and address for Molina. If Molina is not the primary payer under the Coordination of Benefits or Third-Party Liability section of this Agreement, 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 this timeline are not eligible for payment from Molina and Provider waives any right to payment.

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract, State Law and Federal Law. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, generally Molina will pay 95% of clean claims within thirty (30) days and 95% of all claims within sixty (60) days.

Molina Payment: Some Participating Providers receive a flat amount for each month that a Member is under their care, whether they see the Participating Provider or not. Some Providers work on a fee-for-service basis, which means they receive payment for each service they perform. Some Providers may receive incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in authorization denials or under-utilization. For more information about how Providers are paid, Members may call Molina Customer Support. Members may also call a Provider's office or medical group for this information.

Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was approved or does not require approval, Molina will repay the Member. The Member must submit the claim for reimbursement within twelve (12) months from the date they made the payment. The Member will need to mail Molina a copy of the bill 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 include a copy of the prescription label. Members must mail this information to Molina Customer Support at the address on the inside cover of this Agreement. After Molina receives the request for reimbursement, Molina will respond to the Member within thirty (30) calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member. If the claim is denied, Molina will send the Member a letter explaining why the claim was denied. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

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

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

- Except in the case of Emergency Services, the Member asks for and gets healthcare services from a Provider or facility that is 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. To the extent that Members receive a third-party recovery via litigation and Molina has a right to repayment, reimbursement, or subrogation under this section, Molina will pay its proportionate share of the Member's attorney fees associated with such litigation.

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

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 Health Benefit Exchange to determine if they are eligible. If the Subscriber is eligible for an Advanced Premium Tax Credit, they can use any amount of the APTC in advance to lower their Premium.

The Health Benefit Exchange can assist Members in determining whether they are a qualifying America Indian or Alaska Native who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina will work with the Health Benefit Exchange in helping our Members.

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

Late Payment Notice: Molina will send written notification to the Subscriber's address of record if full payment of the Premium is not received on or before the Due Date. This notification will inform the Subscriber of the amount owed, include a statement that Molina will terminate the Agreement for nonpayment if the full amount owed is not received prior to the expiration of the Grace Period as described in the Late 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 Premium Payment, they may do so during the Grace Period and avoid losing their coverage. The length of time for of the Grace Period is determined by whether the Subscriber receives an APTC.

Grace Period for Subscribers with APTCs or State Subsidy: 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 APTC or State Subsidy. 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. Pacific time 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 or No State Subsidy: Molina will provide a Grace Period of 30 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an advance payment of the APTC or a State Subsidy. 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 pend payment of all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. Pacific time on the last day of the month prior to the beginning of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

Termination Notification for Non-Payment: Molina will send written notification to a Subscriber informing them when their membership and the membership of their Dependents ended due to non-payment of Premiums. Members may appeal a termination decision by Molina. Please refer to the MolinaMarketplace.com website, the Grievances and Appeals

section of this Agreement, or contact Customer Support for more information of how to file an appeal.

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

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 paid in full, before Molina accepts enrollment of the Subscriber. If a Subscriber pays all past due Premiums, eligible claims that were previously denied as a result of that nonpayment will be reprocessed for payment.

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

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not enrolled with Molina. Coverage for a former Member ends at 11:59 p.m. Pacific time 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 account of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within thirty (30) days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation.

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

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

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

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

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

Member Disenrollment Request: Member requests disenrollment to the Health Benefit Exchange. The Health Benefit Exchange will determine the coverage end date.

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

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

COORDINATION OF BENEFITS (COB)

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

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

1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, individual and group plans offered by carriers licensed by Health Care Service Contractors, 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, 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; medical benefits under group or individual automobile contracts; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. The order of benefit determination rules determine whether this plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

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.

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 one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary.

(iii) 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.

(iv) 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.

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

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

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan: 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.

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.

Right to Recovery: The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Coordination Disputes: Members who believe Molina has not paid a claim properly should first attempt to resolve the problem by contacting Customer Support Follow the steps described in the "Grievances and Appeals" section of this Agreement. Members who are still not satisfied may call the Washington State Office of the Insurance Commissioner for instructions on filing a consumer complaint. Call 1 (800) 562-6900 or 1 (360) 725-7080 or visit Washington State Office of the Insurance Commissioner website at www.insurance.wa.gov.

Notice to Covered Persons: Members who are covered by more than one health benefit plan, and who do not know which plan is primary, should contact any one of the health plans to verify which plan is primary. The health plan the Member contacts is responsible for working with the other plan to determine which is primary and will let the Member know within thirty calendar days.

Note: All health plans have timely claim filing requirements. If a Member or their Provider fails to submit a claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If a Member experiences delays in the processing of their claim by the primary health plan, they or their Provider will need to submit the Member's claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, Members who are covered by more than one plan should promptly report to their providers and plans any changes in coverage. Time limits for primary and secondary plans may be no less favorable than as set forth in the law.

GRIEVANCES AND APPEALS

Definitions Used in Grievances and Appeals

Adverse Benefit Determination: A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or applicant's eligibility to participate in this Plan, as well as 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.

External Review of Adverse Benefit Determination; A request by a Member or the Member's designated representative for an Independent Review Organization to determine whether Molina's Internal Review decisions are correct.

Final External Review Decision: A determination by an Independent Review Organization at the conclusion of an External Review of an Adverse Benefit Determination.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by Molina at the completion of the Internal Review or Appeal process, or an Adverse Benefit Determination for which the Internal Review or Appeal process has been exhausted.

Grievance: Also called a complaint, means a verbal or written complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for, or non-provision of, medical services, including dissatisfaction with medical care, waiting time for medical services, Provider or staff attitude or dissatisfaction with the service provided by Molina.

Independent Review Organization: A certified independent review organization established by the Washington State Insurance Commissioner that is not affiliated with Molina.

Internal Review of Adverse Benefit Determination: The request by or on behalf of a Member to review and reconsider an Adverse Benefit Determination.

Complaint (Grievance): For any problem with any Molina Healthcare services, Molina wants to help fix it. Molina recognizes the fact that Members may not always be satisfied with the care and services provided by Molina's contracted doctors, hospitals, and other Providers. Molina wants to know about any problems and/or complaints. Members may file a Grievance (also called a complaint) in person, in writing, or by telephone. Grievances must be filed within one hundred eighty (180) calendar days from the day the incident or action occurred which caused the dissatisfaction. Molina will never retaliate against a Member in any way for filing a Grievance.

- A Member or a person designated by the Member to assist, can contact Molina's Customer Support center at the telephone number shown in the Reference Guide on page 2 of this Agreement to file a Grievance by phone.
- Grievances may also be submitted in writing by mail or by filing online at the Molina website or address shown in the Reference Guide on page 2 of this Agreement.

- The Customer Support center can also assist Members who need to file a Grievance in a language other than English or need an accessible format. Translation or interpreter assistance is also available.

Molina will send a letter acknowledging receipt of the Member's Grievance within 72 hours of receipt of the request. Grievances will be resolved within thirty (30) calendar days.

Review of Adverse Benefit Determination
Members who receive an Adverse Benefit Determination can file a request for an internal review of the Adverse Benefit Determination. Molina will process written or oral requests for an internal review of an Adverse Benefit Determination, also called an Appeal. There are two levels of appeals, an Internal Review of an Adverse Benefit Determination, and an External Review of an Adverse Benefit Determination. When the Internal Review is final, Members may request an External Review of the Final Internal Adverse Benefit Determination as explained below.

Internal Review of Adverse Benefit Determination
Requests for Internal Review or Appeal of Adverse Benefit Determinations must be received within 180 calendar days of receipt of an Adverse Benefit Determination. Requests for Internal Review or Appeals may be made by calling Molina's Customer Support at the number shown in the Reference Guide on page 2 of this Agreement. Appeals can also be filed in writing to the Customer Support address shown in the Reference Guide on page 2 of this Agreement.

Molina will send a letter acknowledging receipt of the request for Internal Review or Appeal within 72 hours of receipt of the request. Molina's Internal Review or Appeal procedures will be completed within fourteen (14) calendar days for Adverse Benefit Determinations and twenty calendar (20) days for appeals involving Experimental and Investigational procedures. Molina may extend the time it takes to decide by up to 16 additional days if Molina notifies the Member of the extension and the reason for the extension. Any further extensions by Molina are subject to the Member's informed written consent to an extension. An extension will not extend the time for a determination beyond twenty (20) calendar days without the Member's written consent.

Members may submit information, comments, records, and other items to assist in the review. In addition, Members may review and copy Molina's records and information relevant to the claim free of charge. Molina will consider all information submitted prior to making a determination. Molina's review will be performed by persons who were not involved in the original decision and if the Adverse Benefit Determination involved medical judgement, the reviewer will be someone who is or consults with, a health care professional who has appropriate training and experience in the field of medicine encompassing the condition or disease and make a determination that is within the clinical standard of care for that disease or condition.

For Members who are receiving services that are the subject of an Internal Review or Appeal, those services will be continued until the Internal Review or Appeal is resolved. However, if Molina prevails on final determination of the Internal Review or Appeal, the member may be responsible for the cost of the coverage received during the review period.

After the Internal Review or Appeal is complete, Molina will send the Member a written decision no more than two (2) business days after the review has been completed, and will provide information about what information was considered, including the clinical basis for the

determination and how the Member can obtain the clinical review criteria used to help make the decision. If applicable, Molina will also provide the Member with information for obtaining an External Review or Appeal of a Final Internal Adverse Benefit Determination. Molina's decision, and any documents related to the decision, will be provided to the Member at the address Molina has on record for the Member, or with the Member's written consent, such records may be sent electronically.

Expedited Review of Adverse Benefit Determination
Members may request an expedited Internal Review or Appeal of an Adverse Benefit Determination if one of the following conditions applies:

- The Member is currently receiving or has been prescribed treatment or benefits that would end because of the Adverse Determination; or
- If the Member's Provider believes that a delay in treatment based on the standard review time may seriously jeopardize the Member's life, overall health, or ability to regain maximum function, or would subject the Member to severe and intolerable pain; or
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and the Member has not been discharged from the emergency room or transport service.

Requests for expedited Internal Review or Appeal may be made in writing or by telephone. The Member, a person designated by the Member to assist, or the Member's Provider may contact Molina by telephone or in writing at the phone number or address shown in the Reference Guide on page 2 of this Agreement.

If the Member's Provider determines that a delay could jeopardize the Member's health or ability to regain maximum function, Molina will presume the need for an expedited review and treat the review as such, including the need for an expedited determination of an external review.

Members may submit information, comments, records, and other items to assist in the review. Members may review and copy Molina's records and information relevant to the claim free of charge. Molina will consider all information submitted prior to making a determination. This review will be conducted by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers will be individuals who were not involved in making the initial Adverse Benefit Determination.

If Molina requires additional information to determine whether the service or treatment decision being reviewed is covered under this Agreement, or eligible for benefits, Molina will request such information as soon as possible after receiving the request for expedited review.

Molina will notify the Member of the decision regarding an expedited Internal Review no later than seventy-two (72) hours after the initial contact. If the decision was delivered orally, Molina's decision will be issued in writing not later than seventy-two (72) hours after the date of the decision.

Members may also request a concurrent expedited review of an Adverse Benefit Determination, which means that the Internal Review or Appeal and the External Review or Appeal are handled at the same time. Concurrent expedited reviews are available if one of the following conditions applies:

- The Member is currently receiving or has been prescribed treatment or benefits

that would end because of the Adverse Determination.
- If the Member's Provider believes that a delay in treatment based on the standard review time may seriously jeopardize the member's life, overall health, or ability to regain maximum function, or would subject the Member to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and the Member has not been discharged from the emergency room or transport service.

Requests for concurrent expedited review may be made in writing or by telephone. The Member, a person designated by the Member to assist, or the Member's Provider may contact Molina Customer Support by telephone or in writing at the phone number or address shown in the Reference Guide on page 2 of this Agreement.

Molina will issue a formal response no later than 72 hours after receipt of the request. Please see below for more information on External Review or Appeals.

External Review of Adverse Benefit Determination

Within one hundred and eighty (180) days after the Member has received Molina's Final Internal Adverse Benefit Determination, or if Molina has not responded to a request for an Internal Review or Appeal within the time periods noted above, the Member may request an External Review or Appeal from an Independent Review Organization ("IRO"). If External Review or Appeal is not requested, the Internal Review decision is final and binding. Molina may require the Member to exhaust Molina's review process, prior to requesting an external review. If Molina does waive this requirement, and Molina then reverses the final Adverse Determination, Molina will immediately notify the member and the IRO. Members will have an opportunity to appeal to an IRO for Molina's Adverse Benefit Determination related to its obligations under the No Surprises Act. For information on what services are covered under the No Surprises Act, please refer to the "Your Rights and Protections Against Surprise Medical Bills and Balance Billing In Washington State" section of this Agreement. Requests for External Review or Appeals must be in writing and sent to Molina Customer Support at the mailing address or electronic mail address shown in the Reference Guide on page 2 of this Agreement.

Upon receipt of a valid request for an External Review or Appeal, Molina will arrange for the review from an IRO, selected on a rotating basis, at no cost to the Member, and will provide the Member with the IRO contact information within 24 hours of selecting the IRO. The IRO is unbiased and not controlled by Molina. Molina will provide the IRO with the appeal documentation, but the Member may also provide them with information.

The IRO process is optional and the Member pays no application or processing fees of any kind. The Member has the right to give information in support of their request and has 5 business days from the request for an External Review or Appeal to submit any supporting written information to the IRO. If the member is receiving services that are the subject of the Appeal, those services will be continued until the matter is resolved by the IRO. If Molina's Adverse Benefit Determination is upheld by the IRO, the member may be responsible for paying for any services that have been continued during the External Review or Appeal.

The dispute will be submitted to the IRO's medical reviewers who will make an independent determination of whether or not the care is Medically Necessary or appropriate and the application of this Agreement's coverage provisions to the Member's health care services. All documents submitted to the IRO will also be made available to the Member. This includes all relevant clinical review criteria, all relevant evidence, Provider's recommendations, and a copy of this Agreement. The Member will get a copy of the IRO's Final External Review Decision. If the IRO determines the service is Medically Necessary or appropriate for coverage under the Agreement, Molina will provide the health care service.

If the Member's case involves Experimental or Investigational treatment, the IRO will ensure that adequate clinical and scientific experience and protocols are considered.

For non-urgent cases, the IRO must provide its determination within the earlier of fifteen (15) days after the IRO receives the necessary information or twenty (20) days of receipt of their request.

Members may request an expedited External Review or Appeal if one of the following conditions apply:

- The Member receives a Final Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care service for which the Member received emergency services and has not been discharged from the facility.
- The Member received a Final Adverse Benefit Determination involving a medical condition for which the standard external review time would seriously jeopardize the Member's life or health or jeopardize the Member's ability to regain maximum function.
- The Member's request for a concurrent expedited review is granted.

If the External Review or Appeal is expedited, the IRO must notify the Member within 72 hours of its Final External Review Decision. If the notice is not in writing, the IRO must provide the Member with written confirmation of its Final External Review Decision within 48 hours after the date of the decision.

For more information regarding the External Review or Appeal process, or to request an appeal, please call Molina Customer Support at the number shown in the Reference Guide on page 2 of this Agreement.

<u>Washington State Office of the Insurance Commissioner</u>

Members who have any questions or grievances regarding Molina's handling of a grievance or appeal, may contact the Washington State Office of the Insurance Commissioner. A Washington State Office of the Insurance Commissioner representative will review the issues, and if the representative can't help the Member, he or she will point the Member in the right direction for further assistance.

The Washington State Office of the Insurance Commissioner's Consumer Protection Division is currently designated by the U.S. Department of Health and Human Services as the official ombudsman in the State of Washington for consumers who have questions or complaints about health care appeals:

Washington State Office of the Insurance Commissioner
Call 1 (800) 562-6900 or Call 1 (360) 725- 7080
TDD 1 (360) 586- 0241

Fax to 1 (360) 586-2018
Email CAP@oic.wa.gov

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, renew coverage for Members, cancel coverage for Members, or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, individuals with disabilities, disability, sex, or sexual orientation and/or gender identity, or genetic information.

Organ or Tissue Donation: Members can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. Members may choose to be an organ tissue donor by registering with the Washington Department of Licensing when they apply for or renew their Driver's License or Members can go online at www.donatelifetoday.org to add their name to the registry.

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

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

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

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

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

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

Wellness Program: This Agreement includes access to an annual health activity wellness program. The goal of this program is to encourage Members to complete a health activity that supports Member's overall health. The program is voluntary and available at no additional cost. The program is available to all Members eighteen (18) years and older, and those enrolled in a Child-Only Coverage plan. Under this Plan, Members can obtain either an annual comprehensive physical exam through their Primary Care Provider, or an in-home health assessment exam facilitated through Molina. Upon completion of either exam, Molina may assist Members with voluntary follow-up health services to address their needs.

For completing either an annual comprehensive physical exam or an in-home health assessment exam, followed by the completion of a health risk assessment conducted by Molina, Members will receive a program benefit gift card (Maximum program benefit is one gift card per Member, per calendar year). Members will receive the program benefit gift card by mail at the mailing address that is on file with Molina. Members will be provided with a gift card valued at no less than $50 for their participation. For more information, please contact Customer Support.

Health Management: Molina Case Management program currently offers support to Molina members to assist them with a variety of needs.

Molina Case Management staff can help Members manage chronic condition(s) and help Members stay healthy if they have already been diagnosed. Case managers can help Members:

- Better understand their condition (such as heart failure, diabetes, high blood pressure, depression, substance use disorder)
- Better understand their medications and how to take them
- Make the right choices and stay on track with their health goals
- Remove barriers and get Members to the services they need
  To contact a Case Manager please call us toll-free at 888-562-5442 Monday through Friday 8am-5pm (PT)

These programs are voluntary, and Members can choose to remove themself at any time from the programs.

Want to quit smoking? Call the Washington State Tobacco Quit Line at 1-800-Quit-Now, or go online at: https://www.doh.wa.gov/YouandYourFamily/Tobacco/HowtoQuit

Health Management Materials: Helpful information and resources on a variety of chronic health conditions will be available on our website at MolinaMarketplace.com.

Injury Due to Intoxication or Narcotics: This Plan does not exclude services solely because the injury is sustained as a result of the insured being intoxicated or under the influence of a narcotic.

Health Care Benefit Managers: Members can view an updated list of all benefit mangers utilized by the by Molina at MolinaMarketplace.com/HCBM

Your Rights and Protections Against Surprise Medical Bills and Balance Billing

In Washington State

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or on request, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, and providers must tell you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in- network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in- network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at their website or by calling 1-800-562-
6900.

Visit https://www.cms.gov/nosurprises for more information about your rights under

federal law. Visit the Office of the Insurance Commissioner Balance Billing Protection

Act website for more information about your rights under Washington state law.

Non-Discrimination Statement
Molina Healthcare of Washington, Inc.
Molina Marketplace

Molina Healthcare of Washington, Inc. ("Molina") complies with applicable Federal and Washington State civil rights laws that relate to health care services. Molina offers health care services to all members without regard to, and does not discriminate on the basis of, race, color, national origin, age, disability, sex, gender identity, or sexual identity. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
    - Skilled sign language interpreters
    - Written material in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Written material translated in your language
    - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (888) 858-3492, TTY/TTD: 711.

If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. You can also email your complaint to civil.rights@molinahealthcare.com or fax your complaint to (800) 816-3778. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

If you send by mail, please mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also file a civil rights complaint with:

The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal. This is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Washington State Office of the Insurance Commissioner electronically through the Office of the Insurance Commissioner Complaint portal. This is available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

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.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-858-3492 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-858-3492 (TTY: 711).
Chinese	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 1-888-858-3492（TTY：711）。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-858-3492 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-858-3492 (TTY: 711) 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-858-3492 (телетайп: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-858-3492 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-858-3492 (телетайп: 711).
Cambodian (Mon-Khmer)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-858-3492 (TTY: 711)។
Japanese	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。 1-888-858-3492（TTY: 711）まで、お電話にてご連絡ください。
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል: ወደ ሚከተለው ቁጥር ይደውሉ 1-888-858-3492 (መስማት ለተሳናቸው: 711).
Cushite	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-858-3492 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-858-3492 (رقم هاتف الصم والبكم: 711).
Punjabi	ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਵਿੱ ਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। 1-888-858-3492 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-858-3492 (TTY: 711).
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-858-3492 (TTY: 711).