MOLINA HEALTHCARE OF ILLINOIS, INC.

Health Maintenance Organization (HMO)
Out Line of Coverage

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance agreement and only the actual Policy provisions will control. The Policy and associated Policy documents, which are incorporated by reference in the Policy, sets forth, in detail, the rights and obligations of both You and Molina Healthcare of Illinois, Inc. it is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Policy Issuance: This Molina Healthcare of Illinois, Inc. Agreement and Individual Evidence of Coverage (also called the "Agreement") is issued by Molina Healthcare of Illinois, Inc., ("Molina,"), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Molina agrees to provide the Covered Services as outlined in this Agreement.

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

An HMO Policy requires that the Member uses In-Network Participating Provider.

Participating Provider (In-Network 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.

Non-Participating Providers:
WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy.

YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

To **obtain additional information**, including Provider information write to the following address or call the toll-free number:

Molina Healthcare of Illinois, Inc.
Attn: Customer Support Center
1520 Kensington Rd, Suite 212
Oakbrook, IL 60523
Toll Free Number: 1 (833) 644-1623
Monday through Friday,
Central Time Zone
TTY: 771
Online Access: MyMolina,com

Covered Services and Benefits: Please refer to the Agreement and documents that are incorporated by reference in the Agreement for plan specific information. Cost Share amounts specific to the Member's plan are available on the plan specific Schedule of Benefits and Summary of Benefits and Coverage.

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

- Services obtained from a Participating Provider will be reimbursed at the contracted rate for such Covered Services.
- Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of:
  - Molina's median contracted rate for such service(s),
  - 100% of the published Medicare rate for such service(s), or
  - Molina's usual and customary method for determining payment for such service(s).
- All other Covered Services received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina's median contracted rate for such service(s), 100% of the published Medicare rate for such service(s), Molina's usual and customary rate for such service(s), or a negotiated amount agreed to by the Non-Participating Provider and Molina.

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:

- the individual OOPM will be met, with respect to the Member, when that person meets the individual OOPM amount; or
- 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.

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

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

Family Deductible: Applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Individual Deductibles paid by each Family Member during a Year. Each Member can contribute up to the Individual Deductible amount toward the Family Deductible. Once the Family Deductible amount is satisfied in a Year, any remaining Individual Deductibles will be waived for the remainder of the Year. Please refer to the Schedule of Benefits or Summary of Benefits and Coverage to see what Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan.

2022 | Agreement and Individual Policy

Molina Healthcare of Illinois, Inc Marketplace

Molina Healthcare of Illinois, Inc.
1520 Kensington Rd, Suite 212
Oakbrook, IL 60523

MOLINA® HEALTHCARE

Pediatric Dental Notice: This Policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand- alone product. Please contact Molina Healthcare Customer Service Department at: (833) 644-1623, Your agent, or the Health Insurance Marketplace (Marketplace), if You wish to purchase pediatric dental coverage or a stand-alone dental services product.

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. Returning this policy after the annual open enrollment period ends individual the Subscriber or Dependent will not be able to purchase another policy until next open enrollment or qualified special enrollment period.

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

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

Non-Participating Providers:
WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy.

YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

A Non-Participating Provider (Out-of-Network Provider): A Provider who does not have a Participating Provider agreement in effect with Cigna at the time services are rendered. Services from Non-Participating Providers are not covered, except for an Emergency Medical Condition. You will be responsible for the full cost of non-emergency services from a Non-Participating Provider.

MOLINA REFERENCE GUIDE

Service	Need	Where to Go
Emergency Services	• Treatment of an Emergency Medical Condition	**Call 911**, or go to any Emergency room, even if it is a Non-Participating Provider or outside of the Service Area.

Getting Care	• Urgent Care
	  ○ Minor Illnesses
	  ○ Minor Injuries
	• Virtual Care
	• 24-hour advice on medical and mental health questions
		Urgent Care Centers
		Find a Provider or Urgent Care center
		MolinaHealthcare.com/ProviderSearch
		
		Virtual Care
		www.teladoc.com/molinamarketplace
		1-800-TELADOC
		
		24-Hour Nurse Advice Line
		1-833-657-1982 English and Spanish

Online Access	• Find or change a doctor • View benefits and Member Handbook • View or print ID card • Track claims	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaHealthcare.com/ProviderSearch
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card support • Access to care • Payment questions	**Molina Customer Support Center** **1-833-644-1623** Monday through Friday, Central Time Zone **Go to** MyMolina.com **Go to** MolinaPayment.com
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report change of address or income	1 (800) 318-2596 **Go to** healthcare.gov

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

TABLE OF CONTENTS

CONTENTS

Welcome to Molina Healthcare!

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

We're sending you this 2022 Molina of Illinois Agreement and Individual Policy ("Agreement") to tell you:

- How you can get services through Molina
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Molina Member
- How to contact Molina

Please read this Agreement carefully. Inside is information about a wide range of health needs and services provided. Contact us if you have questions or concerns, or need details about:

- Getting an interpreter
- Checking on Prior Authorization status
- Choosing a Primary Care Provider (PCP)
- Paying a premium or for a Covered Service
- Making an appointment.
- Your benefits or your Plan

You can reach Customer Support at MolinaMarketplace.com or 1-833-644-1623.

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 capitalized and are explained in this Definitions section.

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

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.

- Services obtained from a Participating Provider will be reimbursed at the contracted rate for such Covered Services.
- Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of:
  - Molina's median contracted rate for such service(s),
  - 100% of the published Medicare rate for such service(s), or
  - Molina's usual and customary method for determining payment for such service(s).
- All other Covered Services received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina's median contracted rate for such service(s), 100% of the published Medicare rate for such service(s), Molina's usual and customary rate for such service(s), or a negotiated amount agreed to by the Non-Participating Provider and Molina.

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:

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- the family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount.

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

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

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

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

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.

Coordinated Home Care Program: An organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

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

Covered Service or Covered Services: Medically Necessary services, including some medical devices, equipment, and prescription drugs, that Members are eligible to receive 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 or Summary of Benefits and Coverage to see what Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan.

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

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

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

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

Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- 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;
- serious dysfunction of any bodily organ or part;
- inadequately controlled pain; or
- with respect to a pregnant woman who is having contractions:
    - Inadequate time to complete a safe transfer to another hospital before delivery; or
    - A transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

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

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

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

Exigent: A health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a nonformulary drug.

FDA: The United States Food and Drug Administration.

Health Status-Related Factor: Any of the following factors:

- Health status;
- Medical condition, including both physical and mental illnesses and behaviors related to health status;
- Claims experience;
- Receipt of health or behavioral health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including contributions arising out of acts of domestic violence;
- Disability

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

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

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

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

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

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

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

Other Practitioner: A Participating 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 Dependents, if applicable, that provides benefits for Covered Services. Depending on the services, Member Cost Sharing may apply.

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, or Physician Assistant, as allowed under state law and the terms of the Pan, who provides, coordinates, or helps a Member access a range of health care services.

A member has the right to select a **Woman's Principal Health Care Provider (WPHCP)**, Illinois law allows You to select a WPHCP in addition to Your selection of a PCP. A WPHCP is a Physician specializing in obstetrics and gynecology (OB-GYN) or specializing in family practice.

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 or Summary of Benefits and Coverage: A listing of Covered Services with applicable Member Cost Sharing.

Service Area: The geographic area where Molina has been authorized by the State to market individual products sold through the Marketplace, enroll Members obtaining

coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

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

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

Surprise Bill:
(1) a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

(a) emergency care provided by the nonparticipating provider; or

(b) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where:

1) a participating provider is unavailable;

2) a nonparticipating provider renders unforeseen services; or

3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render

(2) does not mean a bill:

(a) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or

(b) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care or for services rendered pursuant to Subparagraph (b) of Paragraph (1) of this subsection."

Surprise Billing: Occur when a Member receive a bill from a Non-Participating Provider that exceeds their cost-sharing obligation for the Covered Service in one of the two following situations:

- They go to a Non-Participating Provider for Emergency care, excluding ambulance transportation; or
- They go to a Non-Participating Provider at a Participating Provider's Health Care Facility and (i) a Participating Provider is unavailable, (ii) a Non-Participating Provider renders unforeseen services, or (iii) a Non-Participating Provider renders services for which they did not give specific consent for that Non-Participating Provider to render the particular services rendered.

Surprise Bill Reimbursement Rate: The sixtieth percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill

reimbursement rate shall be paid at less than one hundred fifty percent of the 2017 Medicare reimbursement rate for the applicable health care service provided.

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

ENROLLMENT AND ELIGIBILITY

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

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

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

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

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

- **Spouse, Domestic Partner, or Party to a Civil Union :** The individual lawfully married, in a Domestic Partnership, or Civil Union with 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 26.

  Coverage will continue until the age of 30 if the eligible child meets the following eligibility criteria:

- is an Illinois resident
- served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
- has received a release or discharge other than a dishonorable discharge.

- **Child with a Disability:** A child who reaches the age of 26 is eligible to continue to be a Dependent if the child meets the following eligibility criteria:
  - The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
  - The child of any age is chiefly Dependent upon the Subscriber for support and maintenance 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:** An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but isn't married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace and State Law.

- **Party to a civil union**: means a person who has established a civil union pursuant to Illinois Religious Freedom Protection and Civil Union Act.

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

- **Spouse, Domestic Partner, or Party to a Civil Union :** A Spouse, Domestic Partner, or Party to a Civil Union 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 date establishment of a Domestic Partnership, or became a party to a Civil Union
  - The Spouse, Domestic Partner, or Party to a Civil Union gains status as a citizen, national, or lawfully present individual
  - The Spouse, Domestic Partner, or Party to a Civil Union 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, establishment of a Domestic Partnership, or become a party to a Civil Union, birth, placement for adoption, placement in foster care, adoption, placement for adoption, child support, or other court order.
    - The Child gains status as a citizen, national, or lawfully present individual
    - The Child permanently moves into the Service Area.

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

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

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

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

Continued Eligibility: If a Member is no longer eligible for coverage under this Plan, Molina will send a written notification at least 30 days before the effective date on which

the Member will lose eligibility. The Member can appeal the loss of eligibility with the Marketplace.

PREMIUM PAYMENT

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

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

Payment: Molina accepts Premium Payments online, by phone, by mail, and through money order. Please refer to the MolinaPayment.com or contact Customer Support for further information. Premium 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 payment, they may do so during the Grace Period and avoid losing their coverage. The length of time for the Grace Period is determined by whether the Subscriber receives an APTC.

- **Grace Period for Subscribers with APTCs**: Molina will provide a Grace Period of 3 consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, is receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for services in the second and third months of the Grace Period; Molina will terminate this Agreement as of 11:59 p.m. Central 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: Unless a longer period is required by law,** Molina will provide a Grace Period of 31 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are

not receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. Central Time Zone on the last day of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

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

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

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

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

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not enrolled with Molina. Coverage for a former Member ends at 11:59 p.m. Central time Zone on the day before the termination date. Molina will provide notice of termination to the Member, including reason for termination, at least 30 days prior to the termination date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date. Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within 30 days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation. Molina may terminate or non-renew a Member for any of the following reasons:

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

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by the Marketplace and Molina. The Marketplace will send the Member notification of loss of eligibility. Molina will also send the Member written notification when informed that the Member no longer resides within the Service Area. Coverage will end at 11:59 p.m. 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: If the 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 rescission of coverage, and the Member's coverage will end at 11:59 p.m. Central Time Zone 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. Members may appeal the rescission of coverage.

Member Disenrollment Request: Members may request disenrollment to the Marketplace or Molina. Coverage will terminate upon 14 days after the Member provides notice of their request for disenrollment.

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

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

CONTINUITY OF CARE

Members receiving an active course of treatment for covered services from a Participating Provider whose participation with Molina is ending without cause may have a right to continue receiving Covered Services from that Provider until the active course of treatment is complete or for 90 days, whichever is shorter, at in-network Cost Sharing. An active course of treatment is:

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

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

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

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

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

- Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through the Prior

Authorization review process. Members may contact Molina to initiate Prior Authorization review.

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

ACCESS TO CARE

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

24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is 833-657-1982.

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

- Emergency Services
- Services from a Non-Participating Provider that are subject to Prior Authorization
- Exceptions described below under No Participating Provider to Provide a Covered Service section
- 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. Non-Participating Provider are not covered unless related to Emergency Services as required by the ACA.

Member ID Card: Members should always carry their Member identification (ID) card with them. Members must show their ID card every time they receive Covered Services. For a replacement ID card, visit MyMolina.com or contact Customer Support.

Digital versions of the ID card are available through MyMolina.com and the Molina Mobile App.

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

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

Members can request to change their PCP at any time at MyMolina.com or by contacting Customer Support.

Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP, with no referrals required. Sometimes a Member may not be able to select the PCP from the Provider Directory they want. This may happen because:

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

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

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

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

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

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

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

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

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important product materials will be made available in accessible formats for persons with low vision or who are blind. Large print 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 Customer Support.

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

PRIOR AUTHORIZATION

Timeframe:

Routine PA: No longer than fourteen (14) calendar days from the initial receipt of the request

Urgent PA: 72 hours

Some services and drugs must be approved by Molina before they will be covered for a Member. This process is called Prior Authorization or Preauthorization. Most Covered Services are available to a Member without 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. For a complete list of Covered Services that do and do not require Prior Authorization, please visit MolinaMarketplace.com/ILGetCare or call Customer Support. The following services always require authorization:

- Hospital/outpatient stay (non-Emergency)
- Surgery
- Durable Medical Equipment

Molina will decide about authorization for a service after receiving the request and all medical information necessary to decide. Providers may request that Molina expedite the authorization process if the standard process would risk the Member's health. Molina will notify the Provider about the decision at the conclusion the approval process, within timeframes required by State and Federal Law. If the request for service is not approved by Molina, the Member will be notified, including rights about how to appeal the denial. Prior Authorization requirements for Covered Services are subject to change, and Members should contact Customer Support or visit MolinaMarketplace.com prior to receiving services.

Authorization Decision Timeframes

Medical Services:

- **Routine Prior Authorization Requests:** Will be processed within five (5) business days from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination, and no longer than fourteen (14) calendar days from the initial receipt of the request.
- **Expedited Prior Authorization Requests** - For medical conditions (that are not Emergency Medical Conditions) which a Member's Provider believes may cause a serious threat to a Member's health, are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination or, if shorter, the period of time required under Section 2719 of the Federal Public Health Services Act and subsequent rules and regulations issued thereunder.
- **Emergency Medical Conditions**: Do not require Prior Authorization.

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

Medical Necessity: Prior Authorization determinations are made based on a review of Medical Necessity for the requested service. The Member's provider will submit a request to Molina.

If a Member has questions about how a certain service may be approved, visit MolinaMarketplace.com or contact Customer Support. Molina is here to help throughout this process and can explain how that type of decision is made.

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

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

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

Utilization Review: Licensed Molina staff processes Prior Authorization requests and conducts concurrent review. Upon request, Providers on behalf of 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, covered services will continue in accordance with Molina case management and until appeal decision. For non-Emergency admissions, a Member, their Provider, or the admitting facility will need to request precertification at least 14 days before the date the Member is scheduled to be admitted. For an Emergency admission, a Member, their Provider, or the admitting facility should notify Molina within 24 hours or as soon as reasonably possible after the Member has been admitted. For outpatient and inpatient non-Emergency medical services requiring Prior Authorization, a Member's Provider, or the admitting facility must notify Molina at least 14 days before the outpatient care is provided, or the procedure is scheduled. For inpatient acute care, Molina will coordinate services within 48 hours and will continue to follow up every 48 hours. Members may obtain access to their file by contacting Customer Support.

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

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

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

- Obstetrician and gynecologist (OB/GYN)
- Mental health or substance abuse disorder Participating Provider

Standing Referral: If the member has a condition that requires ongoing care from a specialist or other health care provider and a referral is required under this policy, the member may request from the member's primary care provider a standing referral. A standing referral may be effective for up to one year and can be renewed if needed. You may contact Molina to learn more about the criteria and conditions related to obtaining a standing referral.

Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider. Following a recommendation for elective surgery. Coverage will be provided at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in the member's opinion, is not resolved by the first consultation.

COORDINATION OF BENEFITS (COB)

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

Definitions:

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for

members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

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

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

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

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

C. The order of benefit determination rules determines whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

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

1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.

2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule

reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

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

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

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary. (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows: (a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

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

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

(c) For a Dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

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

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

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

Facility of Payment: A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Molina will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case

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

COST SHARING

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

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

COVERED SERVICES

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

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

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

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

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

Under the ACA and its corresponding federal regulations governing EHBs:

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

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

Amino Acid-Based Elemental Formulas: Molina covered medically necessary amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when prescribed by a Participating Provider.

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:

- 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
- The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and Prior Authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. If a Member qualifies, Molina cannot deny their participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Member's routine patient costs associated with their participation in an approved clinical trial for which they qualify. Members will not be denied or excluded from any Covered Services under this Agreement based on their health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial.

Molina does not have an obligation to cover certain items and services that are not routine patient costs, as determined by the Affordable Care Act, even when the Member incurs these costs while in an approved clinical trial. Costs excluded from coverage under this Plan include: The investigational item, device or service itself, items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and any service inconsistent with the established standard of care for the patient's diagnosis.

All approvals and Prior Authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. Members will pay the Cost Sharing they would pay if the services were not

related to a clinical trial. Members should contact Customer Support for further information.

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

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

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer and medically necessary pain medication and therapy related to 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)
- Breast - Fibrocystic Breast Condition

Chiropractic and Osteopathic Services
Molina cover Chiropractic and Osteopathic services for manipulation or adjustment of osseous or articular structures when a condition of an orthopedic or neurological nature necessitates treatment for which falls within the scope of a licensed chiropractor or osteopath. The benefit is limited to a maximum of 25 visits per calendar year.

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

- Dental services for radiation treatment
- Dental anesthesia when medically necessary
- Dental and Orthodontic services for cleft palate
- Services to treat Temporomandibular Joint Syndrome (TMJ) (Please refer to the Temporomandibular Joint Syndrome section of this Agreement)
- Dental services needed due to accidental injury
- Dental Anesthesia Services for dependents under the age of 26 that are diagnosed with Autism

Molina does not provide pediatric dental services under this Agreement.

Diabetes Services: Molina covers the following diabetes related services:

- Diabetes self-management training and education when provided by a Participating Provider
- Telehealth services
- Diabetic eye examinations (dilated retinal examinations)
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting
- Outpatient self-management training
- Routine foot care for Members with diabetes (including for care of corns, bunions, calluses, or debridement of nails) by a Participating Provider within the scope of their license.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Preventive Services including:
  - Diabetes (Type 2) screening
  - Screening for gestational diabetes
- Nutritional counseling

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

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

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

Emergency Services

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

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

Emergency Services by a Non-Participating Provider: Emergency Services for treatment of an Emergency Medical Condition are subject to Cost Sharing. Members should refer to the Cost Sharing for Emergency Services in the Schedule of Benefits or Summary of Benefits and Coverage.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina reserves the right to require a transfer to a Participating Provider facility once the Member has stabilized sufficiently. If Molina requires a transfer, 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 they are stable for transfer and Molina arranges for transfer to a Participating Provider facility, and the Member refuses the transfer, additional services provided in the Non-Participating Provider facility are not Covered Services. The Member will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of-Pocket.

Emergency Services for Sexual Assault Victims: Full coverage is provided for examination, testing and treatment of a victim of a sexual offense to the extent of coverage provided for any other emergency or accident care. Such coverage shall additionally be provided when establishing that sexual contact did or did not occur, testing for the presence of sexually transmitted disease or infection, or examining and treating any injuries and trauma associated with the sexual offense.

Emergency Services Outside the United States: Covered Services include Emergency Services while traveling outside of the United States. For Emergency Services while traveling outside the United States, Members should use that country's or territory's emergency telephone number or go to the nearest emergency room.

Members who receive Emergency Services while traveling outside the United States will be required to pay the Non-Participating Provider's charges at the time they obtain those services. Members may submit a claim for reimbursement to Molina for charges that they paid for Covered Services received from the Non-Participating Provider.

Members are responsible for ensuring that claims and/or records of such services are appropriately translated. They are also responsible for ensuring that the monetary exchange rate is clearly identified when submitting claims for Emergency Services received outside the United States. Medical records of treatment and service may also be required for proper reimbursement from Molina. Claims for reimbursement for Covered Services should be submitted to Customer Support.

Claims for reimbursement of Covered Services for Members traveling outside the United States must be verified by Molina before payment can be made. Molina will calculate the Allowed Amount that will be covered for Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws.

Because these services are performed by a Non-Participating Provider, Members will only be reimbursed for the Allowed Amount. The Allowed Amount may be less than the amount the Member was charged by the Non-Participating Provider. Members will not be entitled to reimbursement for charges for health care services or treatment that are not covered under this Agreement.

Emergency Medical Transportation: Emergency medical transportation (ground and air ambulance), or ambulance transport services provided through the 911 emergency response system are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. By accepting any such payment from Molina, the provider of emergency transportation by ambulance (ground or air) agrees not to seek any payment from the member for services provided to the member as identified in State Law.

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
- 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.
- Fertility Preservation services in accordance with state law

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings and are provided up to 60 treatments per year for conditions which are expected to result in significant improvement within two months.

Hearing Services: Molina covers medically necessary hearing instruments and related services for members when a hearing care professional prescribes a hearing instrument to augment communication as follows:

- Members under age 18
    - Hearing aids and hearing exams are covered when prescribed by a Participating Provider Physician or licensed audiologist;
    - New hearing aids are covered one per ear in a 24-month period.
    - Hearing aids must be obtained from a Participating Provider.
    - Reconditioning and repair of existing aids is covered when Medically Necessary.

        - Related services such as selection, fitting, and adjustment of ear molds to maintain optimal fit is covered when Medically Necessary.
- Members age 18 and older:
    - Hearing aids, including necessary parts, attachments, or accessories, and an ear mold obtained from a Participating Provider Physician, licensed audiologist, or licensed hearing aid dispenser.
    - Related services necessary to assess, select, and adjust or fit the hearing aid, including the audiological exam, replacement ear molds, and repairs.
    - Benefit is limited to $2,500 per aid every 24 months, for the aid and all related services.
- Bone anchored hearing aids (osseointegrated auditory implants).
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical benefit categories in this Agreement.

Non-Covered Services:

- Expenses for hearing aids and related services for Members 18 years of age or older that exceed $2,500 per aid every 24 months.
- Hearing aids for Members under age 18 if more than one per ear in any 24-month period.

Home Healthcare: Molina covers home healthcare services on a part-time, intermittent basis to a Member confined to his or her home due to physical illness – when Prior Authorized and provided by a contracted home healthcare agency for up to 100 visits per plan year. 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.
    - Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a home healthcare agency. Molina will cover up to 100 visits per plan year.
- Physical, occupational, speech or respiratory therapy

Hospice Services: Molina covers hospice services for Members who are terminally ill (a life expectancy of 12 months or less). Members can choose hospice care instead of the traditional services covered by this Plan. Molina covers home hospice services and a semi-private room in a hospice facility.
The following services are covered:

- Coordinated Home Care;
- Medical supplies and dressings;
- Medication;
- Skilled and non-Skilled Nursing;
- Occupational and Physical Therapy;

- Pain management services;
- Physician visits;
- Social and spiritual services;
- Respite Care Service.

Infertility Services: Infertility services for the diagnosis and treatment of Infertility will be covered subject to the following terms, conditions and limitations. Infertility services are covered upon Prior Authorization from a Member's Primary Care Physician or Woman's Principal Health Care Provider and when Preauthorized by Molina that the Member meets all the criteria for coverage. Prescribed and approved services must be received at an Infertility center or other Participating-Provider. Any services not covered are described in the "Exclusion" section of this agreement. The following Infertility services are covered:

- Infertility evaluation by a Participating Physician or Mid-Level Provider.
- Office visits related to the initial evaluation or follow-up appointments.
- Lab and X-ray, Huhner test (post-coital test), hysterosalpingogram, laparoscopy, hysteroscopy, ultrasounds, sperm antibody test, Artificial Insemination, semen analysis, acrosome reaction test, urological evaluation and testicular biopsy.
- In Vitro Fertilization, Uterine Embryo Lavage, Embryo transfer, Gamete Intrafallopian Tube Transfer, Zygote Intrafallopian Tube Transfer and Low Tubal Ovum Transfer.
- Assisted Reproductive Technologies (ART), meaning the treatments and/or procedures in which the human Oocytes and/or sperm are retrieved, and the human Oocytes and/or Embryos are manipulated in the laboratory. ART includes prescription drug therapy used during the cycle where an Oocyte retrieval is performed.
- Outpatient prescription drugs and Specialty Prescription Drugs for the treatment of Infertility as outlined in this Agreement.
- Infertility services after reversal of Sterilization are covered if there is a successful reversal of Sterilization and if the Member's diagnosis meets the definition of Infertility.

Benefit Limitation/Oocyte Retrieval Limitation:

- For treatments that include Oocyte Retrievals, coverage for such treatments will be provided only if the Member has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments. This requirement shall be waived in the event that the Member or partner has a medical condition that renders such treatment useless.
- The completed Oocyte Retrievals that shall be eligible for coverage is four per Plan Year.
    - Except if a live birth follows a completed Oocyte Retrieval, then coverage shall be required for a maximum of two additional completed Oocyte Retrievals.

- Following the final completed Oocyte Retrieval for which coverage is available, coverage for one subsequent procedure used to transfer the Oocytes or sperm to the covered recipient shall be provided.
- The maximum number of completed Oocyte Retrievals that shall be eligible for coverage is six per Plan Year.

Donor Expenses:

- The medical expenses of an Oocyte or sperm Donor for procedures utilized to retrieve Oocytes or sperm, and the subsequent procedure used to transfer the Oocytes or sperm to the covered recipient will be covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening and prescription drugs, will also be covered if established as prerequisites to donation by the insurer.
- Coverage for a known donor is provided. In the event the Member does not have arrangements with a known donor, the use of a contracted facility is required. If the Member uses a known donor, use of contracted Providers by the donor for all medical treatment, including but not limited to testing, prescription drug therapy and ART procedures, is required.
- If an Oocyte Donor is used, then the completed Oocyte Retrieval performed on the donor will count against the Member as one completed Oocyte Retrieval.

Mandibular and Maxillary Osteotomy
A mandibular or maxillary osteotomy is covered only if you have significant functional problems that have not been corrected with Dental and/or orthodontic treatment.

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered hospital services, except in the case of an Emergency or Urgent Care Services.

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

Prior Authorization for covered post-stabilization services is required, Molina will provide access 24 hours a day, 7 days a week to persons designated by Molina to make Prior Authorization determinations. Molina will reimburse for covered post-stabilization medical services if Prior Authorization is approved or after two documented good faith efforts, the treating health care provider has attempted to contact the Molina and neither Molina nor designated persons were accessible or the authorization was not denied within 60 minutes of the request.

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

- Bed, Board and General Nursing Care when you are in:
    - a semi-private room
    - a private room
    - an intensive care unit
- Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work) Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the surgery. These tests are considered part of your Inpatient Hospital surgical stay.

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

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

Mental Health Services (Inpatient and Outpatient): Molina covers inpatient and outpatient mental health services when provided by Participating Providers and facilities acting within the scope of their license. Except for involuntary admissions, all inpatient admissions, and certain outpatient services require Prior Authorization. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria.

A mental disorder is a mental health condition identified in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental disorders covered under this Agreement 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.

Inpatient and outpatient mental health services do not include therapy or counseling (e.g. career, marriage, Civil Union, divorce, parental or job). In addition, inpatient services do not include treatment or testing related to autistic spectrum disorders, learning disabilities or mental disabilities. 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:

- Services for children and adults in day treatment programs
- Services for persons with chronic Mental Disorders provided through a community support program
- Coordinated Emergency Services for Members who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Benefits for these services are to be provided for the time period the Member is experiencing the crisis until he/she is stabilized or referred to another provider for stabilization.

Molina covers the following intensive outpatient psychiatric (IOP) treatment programs at a Participating Provider facility:

- Psychiatric observation for an acute psychiatric crisis
- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis

Mental Health Parity and Addiction Equity Act: Molina complies with the federal Mental Health Parity and Addiction Equity Act. Mental Health Services and Substance Use Disorder benefits are provided in parity with medical/surgical benefits within the same classification or subclassification. Intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services are Covered Services, and may require Prior Authorization.

Non-Emergency Medical Transportation (NEMT): Non-routine, non-Emergency Medically Necessary ground transportation is covered when Molina determines such transportation is needed within Molina's Service Area to transfer a Member from one medical facility to another. This includes NEMT from one hospital to another hospital, from a hospital to a skilled nursing facility or hospice. NEMT is provided by wheelchair lift equipped vehicle, litter/stretcher van or non-Emergency ambulance (both advanced life support and basic life support). When NEMT is needed, Molina will arrange for the transportation to be provided by a Participating Provider transportation vendor. Please

note, this is not a service for which Members can self-refer and any services not arranged by Molina will not be covered.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute Onset Neuropsychiatric Syndrome (PANS) Treatment: Molina provides Medically Necessary covered services for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including coverage for Medically Necessary covered services for intravenous immunoglobulin therapy. Immunoglobulin therapy is also known as immune gamma globulin therapy.

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

Office visits, including:

- Associated medical supplies
- Pre-natal and post-natal visits
- Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of physician. Must include asymptomatic members age 50 and over; African-American men age 40 and over; and members age 40 and over with family history of prostate cancer.
- Chemotherapy and other Provider-administered drugs whether administered in a physician's office, an outpatient or an inpatient setting.
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy
- Routine pediatric and adult health exams
- Allergy testing, injections and serum.
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care.
- Sleep studies. Separate facility Cost Sharing may apply)
- Surveillance tests for ovarian cancer annual screening for female insureds who are at risk for ovarian cancer using:
    - CA-125 serum tumor marker testing;
    - Transvaginal ultrasound; or
    - Pelvic examination.

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

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia;
- Laboratory services;
- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that the Member or the Member's provider notifies Molina.

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

Pasteurized donated human breast milk, which may include human milk fortifiers, is covered if indicated by a prescribing licensed medical practitioner and other conditions of prior authorization are met.

Pregnancy Termination: Molina covers pregnancy termination services to the extent required by the Affordable Care Act, federal law, and by any State Law:

- When the life of the mother is endangered by a physical disorder, physical illness or physical injury
- There is a life-endangering physical condition caused by, or arising from, the pregnancy itself
- When the pregnancy is the result of an alleged act of rape or incest

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

Preventive Services: In accordance with the Affordable Care Act, State Law, 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). Please visit the USPSTF website for preventive services recommendations at: uspreventiveservicestaskforce.org
- Immunizations for routine use in children, adolescents, and adults to prevent or arrest the further manifestation of human illness or injury including but not limited to allergy injections and allergy serum 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);
- With respect to women, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA or required by state law and
- Preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- In accordance with State Law, preventive services include:
    - Whole body skin examination for the detection of skin cancer
    - Human Papillomavirus Vaccine (HPV) • HIV screening - pregnant women
    - Shingles vaccine
    - Clinical breast examinations as indicated by guidelines of practice, performed by a Participating Provider within the scope of their license, to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

    - Every 3 years for women at least 20 years of age but less than 40 years of age; and
    - Annually for women 40 years of age or older.
- A low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer as follows:
    - A baseline mammogram for women 35 to 39 years of age.
    - An annual mammogram for women 40 years of age or older.
    - A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.
    - A comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary
    - A screening MRI when medically necessary
    - Tobacco use screening and cessation interventions for tobacco users

- A diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.
- Contraception for women: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling
- Colorectal cancer screening as prescribed by a Participating Provider, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.
- HIV screening and counseling for adolescents, and adults at higher risk
- Prenatal HIV testing ordered by a Participating Provider
- Medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis
- An annual cervical smear or Pap smear test for female members
- Prostate screening
- Ovarian cancer screening
- Breast Feeding (Lactation) Support, Supplies and Counseling - Breast Pumps in accordance with state law

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

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

Preventative Physical Therapy: Molina covers medically necessary physical therapy that is prescribed by a Participating Provider licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

Prosthetic, Orthotic, Internal Implanted and External Devices: Molina covers the internal and external devices when Prior Authorized and under the following conditions:

Prior Authorized Prosthetics are covered when:

- Required to replace all or part of an organ or tissue of the human body, or
- Required to replace all or part of the function of anon-functioning or malfunctioning organ or tissue.

Prior Authorized Orthotic Devices are covered when:

- Provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces.

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 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). Covered Services are limited to a single purchase of each type of prosthetic device every 3 years.

Molina does not cover orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics defined as an in-shoe device, 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.

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, conditions resulting from accidental injuries, developmental abnormalities, scars, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.
- **Removal of breast implant if medically necessary.**

The following reconstructive surgery services are not covered:

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

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Molina covers up to 60 treatments per calendar year for outpatient.

Skilled Nursing Facility: Molina covers 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
- Surgical dressings or supplies

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Substance Use Disorder (Inpatient and Outpatient): Molina covers Medically Necessary inpatient and outpatient treatment for substance use disorder including diagnosis, detoxification, and treatment of the medical complications of the abuse of or addiction to alcohol or drugs. Inpatient coverage, in a Participating Provider hospital, is only covered for medical management of withdrawal symptoms. Coverage includes room and board, Participating Provider physician services, dependency recovery services, education, and substance abuse/chemical dependency when Prior Authorized. 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
- Individual and group substance abuse counseling
- Individual substance abuse evaluation and treatment
- Intensive outpatient programs (IOP)
- Medical treatment for withdrawal symptoms
- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs)

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

Rehabilitation services on an inpatient basis, for up to 45 days inpatient care per calendar year. Care in a day hospital, residential non-hospital or intensive outpatient treatment mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by the member's primary care physician. 60 individual outpatient care visits per member per calendar year as appropriate for evaluation, short-term treatment, and crisis intervention services. Group outpatient care visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by the member's primary care physician. Prolonged rehabilitation services in a specialized inpatient or residential facility are not covered

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

Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Assistant surgeon
- Discharge planning
- Operating and recovery rooms
- Blood transfusion services, processing and the administration of whole blood and blood components and derivatives

Outpatient surgery services provided in any of the following locations:

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

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

Temporomandibular Joint Syndrome ("TMJ")/ Oral Surgery Services: Molina covers services to treat temporomandibular joint syndrome if all the following conditions apply:

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

Covered Oral Surgery Services are limited to:

- Anesthesia Services in accordance with state law
- Surgical removal of complete bony impacted teeth;
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

Tick-borne disease Services: Molina covers a Tick-borne a disease caused when an infected tick bites a person and the tick's saliva transmits an infectious agent (bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

- A severe infection with borrelia burgdorferi;
- A late stage, persistent, or chronic infection or complications related to such an infection;
- An infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and
- The presence of signs or symptoms compatible with acute infection of borrelia or other tick-borne diseases.

Coverage is as follows:

- long-term antibiotic therapy, including necessary office visits and ongoing testing, for a person with a tick-borne disease when determined to be medically

necessary and ordered by a physician licensed to practice medicine in all its branches after making a thorough evaluation of the person's symptoms, diagnostic test results, or response to treatment.

- An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a tick-borne disease if the drug has been approved by the United States Food and Drug Administration.

Transplant Services: Molina covers transplants of organs, tissue, or bone marrow at Participating Provider facilities when Prior Authorized in accordance with state law. 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. If the Member is the recipient of the transplant, services will be provided for transportation and lodging for the Member and one companion. If the recipient of the transplant is a dependent child under the limiting age of this Policy, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed. These services must be directly related to a covered transplant for the Member. Covered Services may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications. Molina guidelines for donor services are available by calling Customer Support.

Molina covers medically necessary immunosuppressant drugs with a written prescription after an approved human organ transplant when issued to inhibit or prevent the activity of the immune system of the member to prevent the rejection of the transplanted organs and tissues, in accordance with state law. When a participating provider has indicated on the member’s approved prescription "MAY NOT SUBSTITUTE" Molina will not require, or cause a pharmacist to interchange another immunosuppressant drug or formulation, without notification and the documented consent of the prescribing participating provider and the member. This does not apply to immunosuppressant drugs for the treatment of autoimmune diseases or diseases that are most likely of autoimmune origin.

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

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

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

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

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

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

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

Laser corrective surgery is not covered.

PRESCRIPTION DRUGS

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

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

Molina Formulary: Molina establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the "Formulary". The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with any coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on the MolinaMarketplace.com. A hardcopy is also available 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.

Insulin limit: Insulin is limited cost sharing of $100 for 30-day supply.

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

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

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

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

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

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

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

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

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

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

Drug Tier	Description
Tier 1	Preferred Generic drugs; Lowest Cost Sharing.
Tier 2	Preferred Brand-Name drugs; Higher Cost Sharing than Tier 1
Tier 3	Non-Preferred, Brand-Name and Generic drugs; Higher Cost Sharing than lower tier drugs used to treat the same conditions.
Tier 4	All Specialty Drugs; Brand-Name and Generic; Higher Cost Sharing than lower tier drugs used to treat the same conditions if available. Depending on state rules, Molina may require Members to use the network specialty pharmacy.
Tier 5	Nationally recognized preventive service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 Cost Sharing.
DME	Durable Medical Equipment ("DME")- Cost Sharing applies; some non-drug products on the Formulary have Cost Sharing determined by the DME 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 in cost between the Formulary generic drug and the brand-name drug

Drug Cost Sharing Assistance and Out-of-Pocket Costs: Cost Sharing reduction for any prescription drugs obtained by Members through the use of a discount card, a coupon provided by a prescription drug manufacturer, or any form of prescription drug third party Cost Sharing assistance will apply toward any Deductible, copay, or cost-sharing responsibility, or the Annual Out-of-Pocket Maximum under the Plan.
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Over-the-Counter Drugs and Supplements: Molina covers over-the-counter drugs and supplements in accordance with State Law and Federal laws.

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

Formulary also includes coverage for opioid Medical Assisted Treatment (MAT) products, intranasal opioid reversal agents, topical anti-inflammatory medications for acute and chronic pain, inhalants as required by state law and epinephrine injectors.

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, Glucagon emergency Kit and select pen delivery systems for the administration of insulin.

Prescription Drugs to Stop Smoking: Molina covers 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 3-month supply through a contracted mail order pharmacy or other Plan programs. Quantities that exceed the day supply limits on the Formulary are not covered, with few exceptions and in accordance with state law.

Proration and Synchronization: Molina provides medication proration for a partial supply of a prescription drug if the Member's pharmacy or Provider 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 and complies with State Law. The proration described will be based on the number of days' supply of the drug dispensed.

Opioid Analgesics for Chronic Pain: Prior Authorization may be required for pharmacy coverage of opioid pain medications to treat chronic pain. Without a Prior Authorization, 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.

This Agreement limits short-term opioid prescriptions to no more than 7 days.

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

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 can be mailed to a Member within 10 days from order request and approval. Through this option, Members can get a 3-month supply of eligible drugs at reduced Cost Sharing. Cost Sharing for a 3-month supply through mail order is applied at a rate of two times the one-month supply Cost Share at the drug's Formulary tier. Tier 4 Specialty drugs are not eligible for mail order programs. Refer to the MolinaMarketplace.com or contact Member Services for more information.

Off-Label Drugs: Molina will not deny coverage of off-label drug use solely on the basis that the drug will be used outside of the FDA-approved labeling. Molina does cover off-label drug use to treat a covered, chronic, disabling, or life-threatening illness. The drug must be approved by the FDA for at least one indication. The use must be recognized as standard and effective for treatment of the indication in any of the standard drug reference compendia or substantially accepted peer-reviewed medical literature. Molina may require that other treatments that are also standard have been tried or are not clinically appropriate if permitted under State Law. The off-label drug use request must demonstrate Medical Necessity to treat a covered condition when Prior Authorization is required.

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

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

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

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

EXCLUSIONS

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

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

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

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

Chiropractic Services: Chiropractic services are not covered. This exclusion does not apply to any services specifically covered in any section of this Agreement, including the Habilitation and Rehabilitation Services sections

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

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

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

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

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

Gene Therapy: Most gene therapy, including prescription drug gene therapy, is not covered. Molina covers limited gene therapy services in accordance with Molina's medical policies and subject to Prior Authorization.

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

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

Infertility Services All infertility services and supplies are not covered, except as covered in the Covered Services section.

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

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

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

Male Contraceptives: Condoms for male use are not covered, as excluded under the Affordable Care Act.

Massage Therapy: Massage therapy is not covered.

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, supplements, herbal supplements, weight loss aids, and food.

Private Duty Nursing: Nursing services provided in a facility, usually to one patient, are not covered.

Reconstructive Surgery: The following reconstructive surgery services are not covered:

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

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

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

If Molina is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to Molina within 30 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to Molina within these timelines are not be eligible for payment and Provider waives any right to payment

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, Molina will pay the Provider of service within 30 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements. The receipt date of a claim is the date Molina receives either written or electronic notice of the claim.

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

If the bill is for a prescription, the Member will need to complete a Reimbursement Form found in the Pharmacy section of the MolinaMarketplace.com. Include a copy of the prescription label and pharmacy receipt when submitting this form to the address as instructed in the form. After Molina receives the request for reimbursement, Molina will respond to the Member within 30 calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member. If the claim is denied, Molina will send the Member a letter explaining why 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 or Summary of Benefits and Coverage 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.

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.

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

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

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

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

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

This Plan does not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available

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

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

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

Time Limit on Certain Defenses: After 2 years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability (as defined in the Agreement) commencing after the expiration of such 2-year period. No claim for loss incurred or disability (as defined in the Agreement) commencing after 2 years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Agreement.

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

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

Proof of Loss Time of Payment of Claims: Indemnities payable under this Agreement for any loss other than loss for which this Agreement provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Agreement provides periodic payment will be monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Physical Examinations: Molina, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder where it is not forbidden by State and Federal Law.

Automobile Accident Related Injuries: Molina does not exclude coverage for automobile accident related injuries, except as permitted by State Law.

Illegal Occupation or Criminal Activity: Molina is not liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member’s being engaged in an illegal occupation or other willful criminal activity.

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

Members should consult with their PCP before participation. The wellness program is optional, and the benefits are made available at no additional cost to eligible members. For more information, please contact Customer Support.

APPEALS AND GREIVANCES

Complaint: A Complaint is any dissatisfaction that You have with Molina or any Participating Provider that is not related to the denial of healthcare services. For example, the Member may be dissatisfied with the hours of availability of their doctor. Issues relating to the denial of health care services are Appeals and described in the Internal Appeals section below.

If You have a problem with any Molina Healthcare services:

- Call Molina Customer Service
- The Member may also send Molina the problem or complaint in writing by mail or filing online at molinamarketplace.com or you can mail to:

Molina Healthcare of Illinois
1520 Kensington Road,
Suite 212 Oak Brook, IL 60523
Fax: 1 (855) 502-5128
MolinaMarketplace.com

Molina recognizes the fact that Members may not always be satisfied with the care and services provided by Our contracted doctors, hospitals and other providers. A Member may file a complaint in person, in writing, or by telephone as described above. Molina also will provide oral language services that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language. A Member can request that any notice from Molina be provided in any applicable non-English language.

Definitions

Capitalized terms in the Grievances and Appeals section only apply to this section and have the following definitions:

Authorized Representative: An individual authorized in writing by a Member or State Law to act on their behalf in requesting a healthcare service, obtaining claim payment, or during the internal appeal process. A health care Provider may act on behalf of a Member without their express consent when it involves an Urgent Care Service.

Adverse Benefit Determination: An Adverse Benefit Determination is any of the following:

- A determination by Molina that, based upon the information provided, a request for a benefit under the plan upon application of any utilization review technique does not meet Molina's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Molina that a preexisting condition was present before the effective date of coverage; or
- A rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Independent Review Organization (IRO): An organization renders an independent and impartial decision on a Final Adverse Benefit Determination .

Post-Service Claim: Molina rendered an Adverse Benefit Determination for a service that completed.

Pre-Service Claim: Molina rendered an Adverse Benefit Determination and the requested service was not completed.

Urgent Care Services Claim: Molina rendered an Adverse Benefit Determination and the requested service did not complete, where the application of non-Urgent Care appeal periods could seriously jeopardize: A Member’s life or health or the life of the member’s unborn child.

Internal Appeal: A Member, Member’s Authorized Representative, or a treating Provider or facility may submit an appeal of an Adverse Benefit Determination. Molina will provide the Member with the forms necessary to initiate an appeal. A Member may request these forms by contacting Molina Complaints and Appeals. While Member’s are not required to use Molina’s forms, Molina strongly encourages that an appeal be submitted on such form to facilitate logging, identification, processing, and tracking of the appeal through the review process. If a Member needs assistance in preparing the appeal, or in submitting an appeal verbally, a Member may contact Molina for such assistance. A Member or their Authorized Representatives must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination .Within 3 business days of receiving an appeal, Molina will send a Member or their Authorized Representative a letter acknowledging receipt of the appeal. Member’s coverage will remain in effect pending the outcome of their internal appeal. The appeal will be reviewed by personnel who were not involved in the making of the Adverse Benefit

Determination and will include input from healthcare professionals in the same or similar specialty as typically manages the type of medical service under review.

Timeframe: Molina will render a decision to the following types of appeal requests in the following time frames:

- Urgent Care Services: Within 24 hours after receipt of the required information Molina needs to evaluate the appeal
- For concurrent or pre-service: Within 15 business days after receipt of all required information (if the appeal is related to health care services and not related to administrative matters or complaints) or 30 days after the appeal has been received by Molina, whichever is sooner.
- For post-service: Within 15 business days after receipt of all required information (if the appeal is related to health care services and not related to administrative matters or complaints) or 60 days after the appeal has been received by Molina, whichever is sooner.

Exhaustion of Process: The preceding procedures and processes are mandatory and must be exhausted prior to bringing litigation or any administrative proceeding regarding matters within the scope of this section.

General Rules and Information: General rules regarding Molina's Complaints, Grievances (Internal Appeals) and External Appeals Process include the following:

- Molina will offer to speak with a Member by telephone. Appropriate
- arrangement will be made to allow telephone conferencing to be held at
- Molina's administrative offices. Molina will make these telephone arrangements with no additional charge to the Member.
- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.
- Molina will provide Members with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when the initial Adverse Benefit Determination was made. A "full and fair" review process requires Molina to send any new medical information directly to the Member, so they have an opportunity to review the claim file.

Notice of Appeal Determination: Molina will notify the party filing the appeal, the Member, and, any health care provider who recommended the services involved in the appeal, by a written notice of the determination. The written notice will include:

- The medical or clinical basis for the determination;
- A clear detailed statement of the specific medical, dental, or contractual reasons for the resolution;
- A description of or the source of the screening criteria that were utilized in making the determination which is based upon sound clinical evidence and reviewed on a periodic basis;
- Notice of the appealing party's right to seek review of the adverse determination by an IRO relating to Independent Review of Adverse Determinations;

Standard Independent Review Process: A Member may request an independent review of an Adverse Benefit Determination only after exhausting the Molina's internal review process described above unless:

- Molina agrees to waive the internal review process;
- Molina has not complied with the requirements of the internal review process, except where those failures are de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the Member and are not part of a pattern or practice failing to follow the requirements; or
- A Member has requested an expedited independent review at the same time.

Molina will pay the cost for an IRO to conduct a review of an Adverse Benefit Determination . A Member may request an independent review at regardless of the dollar amount of the claim or services involved. A Member must file in writing a request with Illinois Department of Insurance within 4 months of Member's receipt of Molina's appeal review denial. Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance External Review Unit at
1-877-850-4740, by facsimile at 1-217-557-8495,
by email at doi.externalreview@illinois.gov or
at https://mc.insurance.illinois.gov/messagecenter.nsf, or
via their website at
https://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html

A Member may also contact the:

Office of Consumer Health Insurance (OCHI) within the Illinois Department of Insurance
at 320 W. Washington Street, 4th Floor,
Springfield, Illinois, 62767 or at 1
22 South Michigan Ave. 19th Floor,
Chicago, Illinois 60603;
toll free at 877-527-9431; or
at www.insurance.illinois.gov.

You or your authorized representative may include all relevant documentation and any additional information with your appeal request. The Independent Review Organization will render an opinion within 45 days after receiving all necessary information. When requested and when determined a delay would be detrimental to your condition, the review shall be completed within 72 hours or 5 days for expedited experimental/investigational reviews. The Independent Review Program is voluntary for you and is arranged by the Illinois Department of Insurance.

Expedited Independent Review Process: An expedited independent review is available when the Adverse Benefit Determination:

- Involves a medical condition which would seriously jeopardize the life and health of the Member or jeopardize the Member's ability to regain maximum function;

- In the opinion of the Member's attending provider, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Adverse Benefit Determination ;or
- Molina has delayed expedited appeal decision for more than 48 hours.
- Concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services, but has not been discharged from a facility.

To request an External Review or an Expedited External Review, you must send a request to:

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767
Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Once the Illinois Department of Insurance receives your request for external review, they will forward your request to Molina to determine if your request is eligible for an external review.Non-Discrimination Notice

Molina complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.
Molina also complies with applicable State Laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

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

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

If you need these services, contact Molina Customer Support. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711). If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a

complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប៊ែលឬពុម្ពអក្សរធំដោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកដោយមិនគិតថ្លៃបន្ថែម។ (Cambodian)