Marketplace

2022 | Agreement and Individual Evidence of Coverage

Molina Healthcare of Idaho Marketplace

Molina Healthcare of Idaho
7050 Union Park Center, Suite 200
Midvale, Utah 84047

MOLINA® HEALTHCARE

v1.0 5/8/20

MOLINA REFERENCE GUIDE

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

	• Urgent Care
	  ○ Minor Illnesses
	  ○ Minor Injuries
		Urgent Care Centers
		Find a provider or Urgent Care facility
		MolinaHealthcare.com/ProviderSearch

	• Virtual Care	**Virtual Care** www.teladoc.com/molinamarketplace 1-800-TELADOC
Online Access	• Find or change your doctor • View benefits and Member Handbook • View or print ID card • Track claims	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaHealthcare.com/ProviderSearch
Plan Details	• Answers about your Plan, programs, services, or prescription drugs • Request Molina Member materials • ID card support • Access care • Prenatal care • Well-infant visits • Payment Questions	**Molina Customer Support Center** 833-657-1981 Monday through Friday, 8:00 a.m. to 6:00 p.m. Mountain time **Go to** MyMolina.com **Go to** MolinaPayment.com
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report change of address or income	**Your Health Idaho** 855-944-3246 www.yourhealthidaho.org

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

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

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

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

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

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

Pediatric Dental Notice: This Agreement does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent, a stand -alone dental insurance provider or Your Health Idaho if you wish to purchase a stand-alone dental care product.

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Welcome to Molina Healthcare!

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

We're providing you this 2022 Molina Healthcare of Idaho Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

- How you can get Covered 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 833-657-1981.

We look forward to serving you!

Brandon Hendrickson

Brandon Hendrickson
Plan President

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 has a special meaning used in only one section of this Agreement, it is explained in that section. Words with special meaning used in more than one section of this Agreement are explained in this "Definitions" section.

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

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

1. For Covered Services furnished by a Participating Provider: These services shall be reimbursed at the contracted rate with the Participating Provider for such Covered Services.

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

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

3. For all other Covered Services furnished by a Non-Participating Provider in accordance with this Agreement: Except if otherwise expressly required by applicable law, these services shall be reimbursed at the lowest of (a) Molina's median contracted rate for such Covered Service(s), (b) 100% of the published Medicare rate for such Covered Service(s), (c) Molina's usual and customary method for determining payment for such Covered Service(s), or (d) a negotiated amount agreed to by the Non-Participating Provider and Molina.

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

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

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

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

Coinsurance: A percentage of the charges for Covered Services the Member must pay when they receive certain Covered Services. If applicable, Coinsurances are listed in the Schedule of Benefits.

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

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

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

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

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

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

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

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

Emergency or Emergency Medical Condition: An illness, injury, symptom (including severe pain), or condition severe enough that, in the absence of immediate medical attention, could reasonably be expected to result in:

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

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

Emergency Services: 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 ten (10) categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

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

FDA: The United States Food and Drug Administration.

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

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

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

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

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

Molina Healthcare of Idaho (Molina): The company authorized in Idaho as a managed care organization and contracted with the Health Benefit Exchange.

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

Non-Participating Provider: A Provider that has not entered into a contract with Molina to provide Covered Services to Members. Non-Participating Providers can also be referred to as “Out-of-Network” Providers.

Originating Site: means the physical location of a patient receiving health care services through telemedicine. This includes a:

- Hospital
- Rural health clinic
- Federally qualified health center
- Physician's or other health care provider's office
- Community mental health center
- Skilled Nursing Facility
- Home or any location determined by the individual receiving the service
- Renal dialysis center, except an independent renal dialysis center

Other Practitioner: 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. Participating Providers can also be referred to as “In-Network” Providers.

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

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

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

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

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

- Primary Care Doctor

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

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

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

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

Service Area: The geographic area where Molina has been authorized by the State of Idaho 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.

Summary of Benefits and Coverage: A summary of Covered Services and applicable Member Cost Sharing.

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 Idaho. It consists of the state's constitution, statutes, regulations, sub-regulatory guidance state regulatory agency directives and common law.

Telehealth Services: Delivery of Covered Services through audio and video conferencing technology that permits communication between a Member at an Originating Site and a provider at a Distant Site, allowing for the diagnosis or treatment of Covered Services. Also, the communication does not involve in-person contact between the Member and a provider. During the virtual visit the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the provider.

Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Provider may receive the Member's medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as "Store and Forward" technology). Applicable Cost Sharing for Covered Services delivered through Telehealth Services will be charged at either the Primary Care or Specialist care Cost Sharing, depending on the Provider type.

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 Health Benefit Exchange. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber for this Plan.

Open Enrollment Period: The Health Benefit Exchange will set a yearly period in which eligible individuals can apply and enroll in a health insurance plan for the following year. The Effective Date of coverage will be determined by the Health Benefit Exchange.

Special Enrollment Period: 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, called "qualifying life events" established by the Health Benefit Exchange. The effective date of a Member's coverage will be determined by the Health Benefit Exchange. Individuals have 60 days from the date of your event to complete the following:

- Report your qualifying life event
- Provide documentation to prove the event and enrollment eligibility.
- Select and enroll in a plan.

For more information about Open Enrollment, Special Enrollment Periods, and qualifying life events, please visit www.yourhealthidaho.org.

Child-Only Coverage: Molina offers Child-Only Coverage for individuals who, as of the beginning of the Plan year, have not attained the age of 21, and a parent or legal guardian applies on behalf of the individual. For more information regarding eligibility and enrollment, please contact the Health Benefit Exchange.

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

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

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

Child with a Disability: A Child who reaches the age of twenty-six (26) is eligible to continue to be a Dependent if the Child meets the following eligibility criteria:

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

Domestic Partner: A domestic partner of the Subscriber may enroll in this Plan. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Health Benefit Exchange and State Law.

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

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

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

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

- Loss of minimum essential coverage, as defined by the Affordable Care Act
- Becomes a Dependent through marriage, birth, placement for adoption, placement in foster care, adoption, child support, or other court order.
- For an adopted Child, if physical placement in the care of the adopting Member is prevented due to the medical needs of the Child, the date the adopting Member signs an agreement for adoption of the Child and assumes financial responsibility for the Child
- The Child gains status as a citizen, national, or lawfully present individual
- The Child permanently moves into the Service Area.

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

Please note: Claims for newborn Children for eligible Covered Services will be processed as part of the mother's claims and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and Annual Out-of-Pocket Maximum. However, if an enrollment file is received for the newborn during the first sixty (60) days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or Annual Out-of-Pocket Maximum (i.e. not under the enrolled mother's Deductible and Annual Out-of-Pocket Maximum).

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

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

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

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. Molina accepts third party payment toward a Member's Premium in accordance with State Law and Federal Law.

Advanced Premium Tax Credit (APTC): Advanced Premium Tax Credit is a tax credit a Subscriber can take in advance to lower their monthly Premium. Molina does not determine or provide tax credits, and Subscribers must contact the Health Benefit

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

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

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

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

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

Grace Period for Subscribers with APTCs: Molina will provide a Grace Period of 3 consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, is receiving APTC. 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. Mountain 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: Molina will provide a Grace Period of 30 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an advance payment of the APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pend payment of all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. Mountain time on the last day of the month prior to the beginning of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

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

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

If any renewal Premium be not paid within the time granted the Member for payment, a subsequent acceptance of Premium by Molina or by any agent duly authorized by the Molina to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Molina or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Agreement will be reinstated upon approval of such application by the Molina or, lacking such approval, upon the forty-fifth day (45) following the date of such conditional receipt unless the insurer has previously notified the Member in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the Member and Molina shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement**.**

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

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

ACCESS TO CARE

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

Network Requirements: Molina uses a Participating Provider network, also referred to as an "In-network". Providers not in Molina's Participating Provider network are consider Non-Participating Providers, or "Out-of-Network". In-network Deductible and Maximum Out-of-Pocket amounts accumulate separately from the Out-of-Network Deductible and Maximum Out-of-Pocket amounts. Members actual costs for services provided by an Out-of-Network provider may exceed this Plan's Maximum Out-of-Pocket limit for Out-of-Network services. In addition, Out-of-Network providers can bill Members for the difference between the amount charged by the provider and the Molina's Allowed Amount, and this amount is not counted toward the out-of-network out-of-pocket limit. Members should contact Molina Customer Support for additional information.

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

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

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

Primary Care Provider (PCP): A Primary Care Provider (or PCP) takes care of routine and basic health care needs. PCPs provide Members with services such as physical exams, immunizations, or treatment for an illness or injury that is not needed on an urgent or Emergency basis. Molina asks Members to select a PCP from our Participating Provider network in the provider directory. If a PCP is not selected, one will be assigned by Molina. Members can request to change their PCP at any time at MyMolina.com or by contacting Customer Support.

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

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

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

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

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

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

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

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

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

- 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 Provider are in the same physical location
- Do not include texting, facsimile or e-mail only

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

PRIOR AUTHORIZATION

Emergency Medical Conditions: Emergencies do not require Prior Authorization.

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

- Hospital stay (non-emergency).
- Long-Term Care (nursing home or long-term facility)
- Durable Medical Equipment
- Non-Emergency Surgery

Authorization Decision Timeframes

Medical Services:

- **Prior Authorization Requests:** Will be processed within two (2) business days from receipt of all information reasonably necessary and requested by Molina to make the determination.

- **Expedited Prior Authorization requests**: Medical conditions (that are not Emergency Medical Conditions) that a Member's Provider believes may cause a serious threat to a Member's health, authorizations are processed within seventy-two (72) hours from receipt of all reasonably necessary information and requested by Molina to make the determination. The period of time may be shorter if 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.

When Prior Authorization for a Covered Service is required and approved, the approval shall be final and may not be rescinded by Molina after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium,

exhaustion of benefits or if the Member for whom the Prior Authorization was granted is not enrolled at the time the Covered Service was provided.

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

Medical Necessity: Prior Authorization determinations are made based on a review of Medical Necessity for the requested service. Molina is here to help Members throughout this process. If a Member has questions about how a certain service may be approved, they may visit MolinaMarketplace.com or contact Customer Support at the number shown in the Reference Guide on page 2 of this Agreement. Molina can explain how Medical Necessity decisions are made.

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

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

Utilization Review: Licensed Molina staff processes Prior Authorization requests and conducts concurrent review. Upon request, Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations. Molina provides help and alternatives for care when a Member is not authorized for a service. Utilization review criteria based on sound patient care and scientific principles developed in cooperation with licensed physicians and other providers as deemed appropriate by Molina.

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

Second Opinion: A Member or their Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care.

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

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

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

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

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

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

Urgent Care Services and After-Hours Care: Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury. Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. For after hours or Urgent Care Services Members should call their PCP or the Nurse Advice Line.

Emergency Services by a Non-Participating Provider: Emergency Services for treatment of an Emergency Medical problem are subject to cost sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Schedule of Benefits.

Emergency Services Outside the United States: Covered Services include Emergency Services while traveling outside of the Service Area. This includes travel outside of the United States. For Emergency Services while traveling outside the United States, please use that country's or territory's Emergency telephone number or go to the nearest Emergency room.

Members who receive health care 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 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 the Customer Support address shown in the Reference Guide on page 2 of this Agreement.

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 Law and federal law.

Due to these services being 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. Members may be responsible for charges that exceed the Allowed Amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.

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

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

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

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

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

COST SHARING

Molina requires Members to pay Cost Sharing for certain Covered Services under this Agreement. Members should review their Schedule of Benefits for all applicable Cost Sharing for Covered Services. For certain Covered Services, such as laboratory and X-rays that are provided on the same date of service and in the same location as an office visit to a PCP or a Specialist, Members will only be responsible for the applicable Cost Sharing amount for the office visit. Cost Sharing will not be more than the actual charge for the service, drug, or medical equipment.

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

Molina accepts third party payment toward a Member's Cost Sharing in accordance with State Law and Federal Law.

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.

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. With the exception of the EHB category of coverage for pediatric services, Molina does not exclude an Member from coverage in an EHB category.

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

Under the ACA and its corresponding federal regulations governing EHBs:

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

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

Molina covers Medically Necessary services related to treatment of a congenital anomaly. A congenital anomaly is a condition existing at or from birth that is a significant deviation from the common form or function of the body, impairing the function of the body, whether caused by a hereditary or developmental defect or disease.

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 services 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.

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

- Those evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). These recommendations include pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection.

Please visit the USPSTF website for preventive services recommendations at: https://www.uspreventiveservicestaskforce.org.

- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- Preventive services and screenings provided for in comprehensive guidelines supported by state regulation and HRSA to the extent not already included in certain recommendations of the USPSTF.
- Screening for physical, mental, sexual, and reproductive health care needs that arise from sexual assault, regardless of the member's gender.

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

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

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

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

1. The study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, or a qualified non-governmental

research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
2. The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. Members will pay the Cost Sharing they would pay if the services were not related to a clinical trial. Members should contact Molina Customer Support for further information.

Autism Spectrum Disorder Services: Molina covers the diagnosis and treatment of autism spectrum disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as defined by the Diagnostic and Statistical Manual. Molina covers Applied Behavioral Analysis (ABA) and Board Certified Behavioral Analysis (BCBA) Molina covers services provided by a provider that have a current Board Certified Behavioral Analysis certification issued by the Behavioral Analyst Certification Board issued by the Idaho Department of Health and Welfare.

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

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Mammogram coverage at the following periodicity:

    - One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
    - A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
    - A mammogram every year for any woman who is fifty (50) years of age or older.
    - A mammogram for any woman desiring a mammogram for medical cause.
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more information).

Chiropractic Care (Limit 18 visits): Molina covers 18 chiropractic visits by a licensed professional, per Plan year.

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

- Dental services for radiation treatment
- Dental anesthesia for those who would be at risk if the service were performed elsewhere and without anesthesia
- Dental and orthodontic services for cleft palate
- Services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease
- Accidental Dental: Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, Sound Natural Tooth, mouth, or face. Such services are covered only for the twelve (12) month period immediately following the date of injury providing the Policy remains in effect during the twelve (12) month period.

Molina does not provide pediatric dental services under this Agreement.

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

- Diabetes self-management training and education
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting

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

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

Dialysis Services: Molina covers acute and chronic dialysis services, including in both home and outpatient settings, if the Members satisfies all medical criteria developed by Molina.

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

- Diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated
- Prescription birth control supplies
- Follow-up care for any problems Members may have using birth control methods issued by the family planning providers
- Laboratory tests if medically indicated as part of deciding what birth control methods a Member might want to use
- Pregnancy testing and counseling
- Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Any other outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive.
- Contraceptive methods for women currently identified by the FDA include: sterilization surgery for women; surgical sterilization implant for women: implantable rod; IUD copper; IUD with progestin; shot/injection; oral contraceptives (combined pill); oral contraceptives (progestin only); oral

contraceptives extended/continuous use; patch; vaginal contraceptive ring; 12) diaphragm; sponge; cervical cap; female condom; spermicide; and emergency contraception.

Habilitation Services (Limit of 20 visits): Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech, occupational therapy, aural therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Services are limited to a combined 20 visits per calendar year. (This limitation does not apply to Covered Services for autism spectrum disorders).

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

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

- In-home medical care services
- Home health aide services
- Medical social services
- Necessary medical supplies
- Necessary medical appliances
- Nurse visits and part-time skilled nursing services
- 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). Molina also covers respite care as an alternative to hospice care.

Inpatient Hospital Services: Members must have a Prior Authorization to receiving covered Hospital services, except in the case of an Emergency Services. If coverage with Molina terminates during a Hospital stay, the services received after the Member's termination date are not Covered Services. Medically Necessary inpatient services are generally and customarily provided by acute care general Hospitals inside the Service Area. Non-Covered Services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

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

Mental Health Services (Inpatient and Outpatient): Molina covers inpatient and outpatient Mental Health Services. 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 for career, marriage, divorce, parental or job. In addition, inpatient services do not include treatment or testing related to autistic spectrum disorders, learning disabilities or mental 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 outpatient intensive psychiatric treatment programs at a 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

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.

Phenylketonuria (PKU) and other Inborn Errors of Metabolism: Molina covers testing and treatment of phenylketonuria (PKU). Molina also covers other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Provider and managed by a licensed healthcare professional. The health care professional will consult with a physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.

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

- Office visits, including:
  - Associated medical supplies
  - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs administered in a physician's office, an outpatient, or an inpatient setting. These services are subject to either outpatient facility or inpatient facility Cost Sharing.
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an obstetrician/gynecologist (OB/GYN). Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care.

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 involuntary complications of pregnancy, including conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but not false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis qravidarum, preeclampsia and similar conditions associated with

the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

- Laboratory services
- Inpatient Hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that Members or Member's provider notifies Molina.

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, except for otherwise Covered Services provided to a Member who is a surrogate.

Pregnancy Termination: Pregnancy termination, to the extent permitted by State Law and Federal law, is only covered:

- When the life of the mother is endangered by a physical disorder, physical illness, or physical injury
- 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 office-based procedures do not require Prior Authorization. Pregnancy termination services that are provided in an inpatient or outpatient Hospital setting require Prior Authorization.

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

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

In accordance with State Law, preventive services include a range of services for the diagnosis of infertility, well-childcare from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

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

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

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

- Hip joints
- Intraocular lenses
- Pacemakers

External devices:

- Artificial limbs needed due to loss resulting from disease, injury, or congenital defect.
- Custom made prosthesis after mastectomy and up to three brassieres required to hold a prosthesis every 12 months
- 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.

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

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

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

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

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a 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 (limit 20 visits): Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and aural therapy rehabilitation services (limited to 20 visits for the combined services per calendar year) in a variety of inpatient and/or outpatient settings.

Skilled Nursing Facility (limit 30 days): Molina covers 30 days per calendar year at a skilled nursing facility (SNF) for a Member when the SNF is a Participating Provider and the services are Prior Authorized before they begin. Covered SNF services include:

- Room and board
- Physician and nursing services
- Medications and injections

Substance Use Disorder (Inpatient and Outpatient): Molina covers Medically Necessary inpatient and outpatient treatment for Substance Use Disorder. Inpatient coverage, in a hospital, is only covered for medical management of withdrawal. Coverage includes room and board, professional services, dependency recovery services, including detoxification and medical management of withdrawal symptoms, education, and substance/chemical dependency. Molina also provides coverage for Substance Use Disorder treatment in a nonmedical transitional residential recovery setting. Molina covers the following outpatient care for treatment of Substance Use Disorder:

- Day-treatment programs
- Individual and group Substance Use Disorder counseling
- Individual substance use disorder evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs).

Molina does not cover services for alcoholism, Substance Use Disorder, or drug addiction except as otherwise described in this Agreement.

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

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

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

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

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

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

Transplant Services: Molina covers transplants of organs, tissue, or bone marrow at licensed facilities when Prior Authorized. If a provider determines that a Member does not satisfy its respective criteria for a transplant, Molina will only cover services the Member received before that determination is made. Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor. In accordance with Molina guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor, or an individual identified as a potential donor, regardless of whether the donor is a Member. These services must be directly related to a covered transplant for the Member. Covered Services may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications. Molina guidelines for donor services are available by calling Customer Support.

Molina does not cover the following transplant services:

- Transplants of brain tissue or brain membrane, islet tissue, pancreas, intestine, pituitary and adrenal glands, hair transplants, or any other transplant not specifically named as a Covered Service in this section
- Artificial Organs including but not limited to, artificial hearts or pancreases
- Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Member who is eligible to receive benefits for transplant services after benefits for the recipient have been paid, subject to the provisions of this Agreement
- The cost of a human organ or tissue that is sold rather than donated to the recipient
- Transportation costs including but not limited to, ambulance transportation service or air service for the donor, or to transport a donated organ or tissue
- Living expenses for the recipient, donor, or family members, except as specifically listed as a Covered Service in this Agreement
- Costs covered or funded by governmental, foundation or charitable grants or programs; or provider fees or other charges, if no charge is generally made in the absence of insurance coverage.
- Any complication to the donor arising from a donor's transplant surgery is not a covered benefit under the insured transplant recipient's Agreement. If the donor is a Molina Member, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from transplant surgery will be allowed under the donor's policy
- Costs related to the search for a suitable donor

Urgent Care Services: 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 outside of the Service Area may go to the nearest Emergency room. Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits.

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

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

- Comprehensive vision exam limited to 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.

Molina covers the following vision services for Members age 19 and older on Plans with routine adult vision benefits:

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

Members should refer to their Plan's Schedule of Benefits or Summary of Benefits and Coverage for this plan to learn more about routine adult vision coverage under this Plan, available at MyMolina.com or Molina Marketplace.com. Members should contact Molina Customer Support if they have any questions. 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 Molina Marketplace website. A hardcopy is also available upon request made to Customer Support.

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

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 notify 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 not apply toward any Deductible, 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. Covered products are listed on the Formulary.

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 the Molina Marketplace website, or contact Customer Support for more coverage information.

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

Prescription Drugs to Stop Smoking: Molina covers drugs to help Members stop smoking, 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.

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. 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.

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 Molina Marketplace website 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
- Gene Therapy

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

CONTINUITY OF CARE

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

An Active Course of Treatment is:

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

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

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

Molina will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Molina’s Allowed Amount or an agreed upon rate for such services. If Molina and the provider are unable to settle on an agreed

upon rate, the Member may be responsible to the provider for any billed amounts that exceed Molina's Allowed Amount. That would be in addition to any in-network Cost Sharing amounts that Members owe under this Agreement. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Member's Deductible or Annual Out-of-Pocket maximum.

In the event the Molina cancels or refuses to renew this Agreement, this Agreement will provide for an extension of benefits as to pregnancy commencing while the Agreement is in force and for which benefits would have been payable had the Agreement remained in force.

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

1. Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.

2. Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina) may be responsible for coverage until a Member's coverage is effective with Molina.

3. After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider on a Member's behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

4. For Inpatient Services: With the member's assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of inpatient hospital services through discharge of any Inpatient admission. If there is no transition of care provision through the Member's prior insurer or if a Member did not have coverage through an Insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of coverage with Molina, not prior.

EXCLUSIONS

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

Acupuncture: Acupuncture is not covered.

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

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

Certain Exams and Services: The following are not covered unless a Provider determines that the services are Medically Necessary.

- Physical exams and other services that are:
    - Required for obtaining or maintaining employment or participation in employee programs
    - Required for medical coverage, life insurance coverage or licensing, or
    - On court order or required for parole or probation.

Cosmetic Services: Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to medically necessary reconstructive services specifically covered in any section of this Agreement, including breast reconstruction following a mastectomy.

Dental Services: Molina does not cover routine adult dental services. Pediatric dental services can be purchased as a stand-alone product through the Health Benefit Exchange.

Dietitian: A service of a Dietitian is not a Covered Service except for when covered under the nutritional counseling benefit or Hospice Care benefit. Please consult the Schedule of Benefits for additional details.

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

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

Experimental or Investigational Services: Any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in the medical community in the State of Idaho, whether the services are under continued scientific testing and research, whether the

services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

This exclusion does not apply to any of the following:

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

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

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

Hearing Aids: The following are not covered: hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device

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

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

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

Long-Term Care and Custodial Nursing Care: Molina does not cover long-term care or custodial nursing 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.

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.

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

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

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

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

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

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

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

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

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

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

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

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.

Temporomandibular Joint Syndrome (TMJ): Molina does not cover the following services to treat temporomandibular joint syndrome (also known as “TMJ”)

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

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.

Weight Loss Programs: Weight loss programs are not covered.

CLAIMS

Filing a Claim: Providers must promptly submit to Molina claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Molina and must include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Member or Provider to Molina within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.

Claim Forms for Filing Claim: Molina, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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

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

Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was approved or does not require approval, Molina will repay the Member. The Member must submit the claim for reimbursement within twelve (12) months from the date they made the payment. The Member will need to mail Molina a copy of the bill from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom

they are submitting the claim and their policy number. If the bill is for a prescription, the Member will need to include a copy of the prescription label. Members must mail this information to Molina Customer Support at the address on the inside cover of this Agreement. After Molina receives the request for reimbursement, Molina will respond to the Member within thirty (30) calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member. If the claim is denied, Molina will send the Member a letter explaining why the claim was denied. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

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

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

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

LEGAL NOTICES

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

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

described in this Agreement until resolution of the dispute. If Molina provides benefits which duplicate the benefits the Member is entitled to under workers' compensation law, Molina will be entitled to reimbursement for the reasonable cost of such benefits.

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. Mountain time on the day before the termination date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date. Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on account of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within thirty (30) days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation.

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

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

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

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

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

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

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

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

Extension of Benefits for Continuous Loss for Disabled Individuals: Termination of this Agreement will not discontinue benefits for a continuous loss covered under this Agreement if the Member's continuous loss commenced while the Agreement was in force. The extension of benefits for their continuous loss applies to a single inpatient stay where they are admitted prior to the Agreement termination date and their stay extends after the Agreement termination date, including any inpatient readmission that occurs within 30 days of their initial discharge. The extension of benefits for their continuous loss is also subject to any quantitative benefit limitations in the Agreement that they have not exhausted as of the termination date, such as day or visit limitations or maximum dollar amounts allotted for benefits.

COORDINATION OF BENEFITS (COB)

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

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

1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, individual and group plans offered by carriers licensed by Health Care Service Contractors, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care

components of long-term care contracts, such as skilled nursing care, and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

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

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

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

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

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

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

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

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

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

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

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree.

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary.

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits.

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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.

Legal Actions: No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (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 three (3) years after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of this Agreement which, on its effective date, is in conflict with the statutes of Idaho on such date is hereby amended to conform to the minimum requirements of such statutes.

Illegal Occupation: Molina shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

Non-Discrimination: Molina does not discriminate in hiring staff, renewal of coverage for Members, canceling coverage for Members, 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.

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

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

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

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

Governing Law: Except as preempted by federal law, this Agreement will be governed in accordance with State Law and any provision that is required to be in this Agreement

by State Law or federal law shall bind Molina and Members whether or not set forth in this Agreement.

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

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

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.

Wellness Program: 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.

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

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

- Better understand their condition (such as heart failure, diabetes, high blood pressure, depression, substance use disorder)
- Better understand their medications and how to take them
- Make the right choices and stay on track with their health goals
- Remove barriers and get Members to the services they need

Please contact Molina Customer Support for more information regarding Health management.

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

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

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

GRIEVANCES AND APPEALS

Definitions Used in Grievances and Appeals

Adverse Benefit Determination: A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or applicant's eligibility to participate in this Plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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

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

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

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

Independent Review Organization: A certified independent review organization permitted by the Idaho Department Insurance Commissioner that is not affiliated with Molina.

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

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

- A Member or a person designated by the Member to assist, can contact Molina's Customer Support center at the telephone number shown in the Reference Guide on page 2 of this Agreement to file a Grievance by phone.
- Grievances may also be submitted in writing by mail or by filing online at the Molina website or address shown in the Reference Guide on page 2 of this Agreement.
- The Customer Support center can also assist Members who need to file a Grievance in a language other than English or need an accessible format. Translation or interpreter assistance is also available.

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

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

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

Molina will send a letter acknowledging receipt of the request for Internal Review or Appeal within 72 hours of receipt of the request. Molina's Internal Review or Appeal

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

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

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

After the Internal Review or Appeal is complete, Molina will send the Member a written decision no more than two (2) business days after the review has been completed, and will provide information about what information was considered, including the clinical basis for the determination and how the Member can obtain the clinical review criteria used to help make the decision. If applicable, Molina will also provide the Member with information for obtaining an External Review or Appeal of a Final Internal Adverse Benefit Determination. Molina's decision, and any documents related to the decision, will be provided to the Member at the address Molina has on record for the Member, or with the Member's written consent, such records may be sent electronically.

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

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

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

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

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

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

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

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

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

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

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

External Review of Adverse Benefit Determination
Within one hundred and eighty (180) days after the Member has received Molina's Final Internal Adverse Benefit Determination, or if Molina has not responded to a request for an Internal Review or Appeal within the time periods noted above, the Member may request an External Review or Appeal from an Independent Review Organization (IRO). Molina may require the Member to exhaust Molina's review process prior to requesting an external review. If Molina does waive this requirement, and Molina then reverses the final Adverse Determination, Molina will immediately notify the member and the IRO. Requests for External Review or Appeals must be in writing and sent to Molina Customer Support at the mailing address or electronic mail address shown in the Reference Guide on page 2 of this Agreement.

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

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

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

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

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

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

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

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

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

Idaho Department of Insurance: Members who have any questions or grievances regarding Molina's handling of a grievance or appeal may contact the Idaho Department of Insurance. A Idaho Department of Insurance representative will review the issue.

The Idaho Department of Insurance Commissioner's Consumer Affairs Section serves as a free resource, provides general information about insurance and responds to consumer inquiries and complaints. Consumer Affairs Officers work diligently with consumers to help resolve disputes with insurance companies and insurance producers (agents). Their primary purpose as an independent regulatory agency is to provide assistance and advice on matters within the State of Idaho pertaining to a variety of insurance products

Idaho Department of Insurance Commissioner's
Consumer Affairs Section
Call (208) 334-4319 or (800) 721-3272
or visit https://doi.idaho.gov/consumer/Complaint

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)