2021 | Agreement and Individual Evidence of Coverage

Molina Healthcare of New Mexico, Inc Marketplace

Molina Healthcare of New Mexico, Inc.
PO Box 3887
Albuquerque, NM 87190

MOLINA® HEALTHCARE

PEDIATRIC DENTAL NOTICE: THIS EOC DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS COVERAGE IS AVAILABLE IN THE HEALTH INSURANCE MARKETPLACE. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR THE FEDERALLY FACILITATED HEALTH INSURANCE MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STANDALONE DENTAL PRODUCT.

Services for Limited Plans for American Indians and Alaska Natives

- For individual Plans with zero Cost Sharing, American Indians/Alaskan Natives do not have Cost Sharing when they receive services Covered Services from Participating Providers.
- For individual Plans with limited Cost Sharing, American Indians/Alaskan Natives do not have Cost Sharing when they receive Covered Services Indian Health Care Provider, or from another Provider if they have a referral from an Indian Health Care Provider. For more information, please visit the Marketplace website.

“Surprise Billing Notices”, pursuant to S.B. 337, Surprise Billing Protection Act:

- Cost Sharing and benefits limitations for an Emergency health care service rendered by a nonparticipating provider shall be the same as if rendered by a participating provider. Prior Authorization shall not be required for Emergency health care services.
- Cost Sharing and benefits limitations for a medically necessary, non-emergent health care service rendered by a non-participating provider at a participating facility where the covered person had no ability or opportunity to choose to receive the service from a participating provider shall be the same as if the service was rendered by a participating provider.
- Cost Sharing and benefits limitations for a medically necessary, non-emergent health care service where no participating provider is available to render the service shall be the same as if the service was rendered by a participating provider.

If a Member pays a non-participating provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the non-participating provider shall refund to the Member within forty-five calendar days of receipt of payment from Molina any amount paid in excess of the in-network cost-sharing amount. In accordance with the hearing procedures established pursuant to the Patient Protection Act - Chapter 59A, Article 57 NMSA 1978, a Member may appeal a Molina's determination made regarding a surprise bill.

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.

Member Participation Committee: Molina wants to hear what the Member thinks about Molina Healthcare. Molina Healthcare has formed the Member Participation Committee to hear Member concerns. The Committee is a group of people that meets once every three (3) months and tells Molina how to improve. The Committee can review health plan information and make suggestions to Molina Healthcare's Board of Directors. If a Member wants to join the Member Participation Committee, please call Molina Healthcare toll-free at 1(888) 295-7651, Monday through Friday, 8:00 a.m. to 5:00 p.m. MT. If the Member is deaf or hard of hearing, call Molina's dedicated TTY line toll free at 1 (800) 659-8331 or dial 711 for the Telecommunications Service. Join Molina's Member Participation Committee today!

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

Age Limits: If the Policy contains an age limit or a date after which coverage provided by the Plan will not be effective, and if such date falls within a period for which Premium is accepted by Molina, or if Molina accepts a Premium after such date, the Policy will remain in force subject to any right of cancellation until the end of the period for which Premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the Policy would not have become effective or would have ceased prior to the acceptance of such Premium or Premiums, then the liability of the Policy shall be limited to the refund, upon request, of all Premiums paid for the period not covered by the Policy.

Service	Need	Where to Go
Emergency Services	• Emergencies and Immediate Care	**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	• Urgent Care
	  ○ Minor Illnesses
	  ○ Minor Injuries
	• Virtual Care
	• Physicals and check-ups
	• Preventive care
	• Immunizations (shots)
		Call your Doctor
		
		Urgent Care Centers
		Find a provider or urgent care center
		MolinaHealthcare.com/ProviderSearch
		
		Virtual Care
		www.teladoc.com/molinamarketplace
		1-800-TELADOC
		
		24-Hour Nurse Advice Line
		1 (888) 275-8750 (English)
		1 (866) 648-3537 (Spanish)

Online Access	• Find or change your doctor • Update your contact information • Request an ID card • Get health care reminders • Track office visits	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaHealthcare.com/ProviderSearch
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card issues • Help with your visits • Prenatal care • Well-infant visits • Payment Questions	Molina Customer Support Center 1 (888) 295-7651 Monday through Friday, 7:30 a.m. to 8:00 p.m. (Local Time) **Go to** MyMolina.com **Go to** MolinaPayment.com
State Regulatory Authority	• Assistance with complaints about Molina or our Providers • Assistance with appeals of a Molina coverage decision	New Mexico Office of Superintendent of Insurance PO Box 1689 Santa Fe, NM 87504-1689 1-855-4ASK-OSI (1-855-427-5674)

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

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

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

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

Welcome to Molina Healthcare!

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

We're providing you this 2021 Molina of New Mexico Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

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

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

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

You can reach Customer Support at MolinaMarketplace.com or 1 (888) 295-7651.

We look forward to serving you!

DEFINITIONS

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

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

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

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

Services obtained from a Participating Provider: This means the contracted rate for such Covered Services.

Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be calculated at the sixtieth percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill reimbursement rate shall be paid at less than one hundred fifty percent of the 2017 Medicare reimbursement rate for the applicable health care service provided.

Non-Emergency services provided by a Non-Participating Provider in a Participating Provider Health Care Facility: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the 60th percentile of allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database specified by the Office of the Superintendent of Insurance (OSI).

All other Covered Services, excluding those outlined in the **“Surprise Billing Notices”**, **pursuant to S.B. 337, Surprise Billing Protection Act**” section of this agreement, received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina’s median contracted rate for such service(s), 100% of the published Medicare rate for such service(s), Molina’s usual and customary rate for such service(s), or a negotiated amount agreed to by the Non-Participating Provider and Molina.

Annual Out-of-Pocket Maximum (also referred to as "OOPM"): The maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM. Note: any amount you are required to pay for services outlined in the **"Surprise Billing Notices", pursuant to S.B. 337, Surprise Billing Protection Act"** section of this agreement will apply to your OOPM. Such services include, Emergency health care service rendered by a nonparticipating provider, non-emergent health care service rendered by a non-participating provider at a participating facility where the covered person had no ability or opportunity to choose to receive the service from a participating provider, and medically necessary, non-emergent health care service where no participating provider is available to render the service. In addition, any associated authorized services will apply to Your OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

- the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
- the family OOPM will be met when Your family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual OOPM amount, We will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family.

Certified Nurse Midwife: Any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse Midwife.

Certified Nurse Practitioner: A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the New Mexico Board of Nursing.

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

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

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

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

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

Covered Service or Covered Services: Medically Necessary services, including supplies and prescription drugs, that Members are entitled to receive from Molina under this Plan.

Cytological Screening: A papanicolaou test or liquid based cervical cytopathology, a human papillomavirus test and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible: A fixed dollar amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

Please refer to the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC) to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

The term “No charge, deductible applies”, means that if you have met your deductible, there is no cost to you for this service. However, if you have not met your deductible, you will have to pay for the services, until you meet your deductible. However for preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services when provided by a Participating Provider.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

- When You meet the Deductible for the individual Member; or
- When Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible

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

Doctor(s) of Oriental Medicine: A person who is a doctor of oriental medicine licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

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

Durable Medical Equipment or DME: Equipment and supplies ordered by a Provider for everyday or extended use. DME may include 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:

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

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

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

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

FDA: The United States Food and Drug Administration.

Health Management Organization: A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

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

Independent Social Worker: A person licensed as an independent social worker by the board of social work examiners pursuant to the Social Work Practice Act (Sections 61-31-1 to 61-31-24 NMSA 1978).

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

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

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

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

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

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

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

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

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

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

Physician Assistant: means a skilled person who is a graduate of a physician assistant or assistant surgeon program approved by a nationally recognized institution, licensed in the State of New Mexico to practice medicine under the supervision of a licensed physician.

Practitioner(s) of the Healing Arts: Refers to a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on, or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

- The Chiropractic Physician Practice Act (Section 61-4-1 NMSA 1978)
- The Dental Health Care Act (Section 61-5A-1 NMSA 1978)
- The Medical Practice Act (Section 61-6-1 NMSA 1978)
- Chapter 61, Article 10 NMSA 1978
- The Acupuncture and Oriental Medicine Practice Act (Section 61-14A-1 NMSA 1978)

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

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, or Physician Assistant, as allowed under state law and the terms of the Pan, who provides, coordinates, or helps a Member access a range of health care services. Pursuant to 13.10.21.7 NMAC (such as Practitioner of the Healing Arts and a Doctor of Oriental Medicine), other health care professionals may also provide primary care.

Prior Authorization: A pre-service determination made by Molina regarding a Member's eligibility for services, medical necessity, benefit coverage, location or appropriateness of services, pursuant to the terms of the health care plan. Prior Authorization is not a guarantee of payment for services when it is discovered that the Prior Authorization was provided based on any material misrepresentation or fraud, on the part of the Provider or the Member, coverage will be denied.

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.

Registered Lay Midwife: Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Rescission of Coverage: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if; the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Premiums, Prepayments, or contributions towards the cost of coverage.

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

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

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 is the body of law in New Mexico. It consists of the state's constitution, statutes, regulations, sub-regulatory guidance state regulatory agency directives and common law.

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

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

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

1) a participating provider is unavailable;

2) a nonparticipating provider renders unforeseen services; or

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

(2) does not mean a bill:

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

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

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

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

Surprise Bill Reimbursement Rate: The sixtieth percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders; provided that no surprise bill reimbursement rate shall be paid at less than one hundred fifty percent of the 2017 Medicare reimbursement rate for the applicable health care service provided.

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

Urgent Care Situation: A situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

- the life or health of the covered person would otherwise be jeopardized;
- the covered person's ability to regain maximum function would otherwise be jeopardized;

- in the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or treatment;
- the medical exigencies of the case require expedited care; or
- the covered person's claim otherwise involves urgent 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, an individual must meet all eligibility requirements established by the Marketplace. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber.

Open Enrollment Period: The Marketplace will set a yearly period in which eligible individuals can enroll in a health insurance plan for the following year. Open enrollment is currently November 15th through December 15th. The Effective Date of coverage will be January 1st or a date determined by the Marketplace.

Special Enrollment Period: If an individual does not enroll during an Open Enrollment Period, they may be able to enroll during a Special Enrollment Period. To qualify for a Special Enrollment Period, an individual must have had certain life events established by the Marketplace. The Effective Date of a Member's coverage will be determined by the Marketplace. For more information about Open Enrollment and Special Enrollment Periods, please visit: MolinaMarketplace.com

Conditions that qualify for a Special Enrollment Period include the following life events. Contact the Health Insurance Exchange if any of the following conditions impact you, or you need additional clarification:

- Getting Married or divorced or legally separated
- Have a child, adopt a child, or place a child for adoption
- Death of someone on your plan
- Change your place of residence
- Have a change in income
- You lose your health coverage, including no longer being eligible for Medicaid or losing your coverage through your job
- Get Health coverage through a job or a program like Medicare or Medicaid
- Change your place of residence
- Have a change in disability status
- Become pregnant
- You return from active-duty military service

- You become a citizen, national or lawfully present individual
- If you are a member of a federally recognized American Indian or Alaska Native tribe, you can enroll anytime and change plans no more than once per month.
- Experience other changes that may affect your income and household size

Other qualifying life events may apply. For more information, visit your Exchange.

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

Dependents: Subscribers who enroll during the Open Enrollment period established by the Marketplace may also apply to enroll eligible Dependents as established by the Marketplace. Dependents must meet the eligibility requirements. Dependents must live in the Service Area for this product and are subject to the terms and conditions of this Agreement. The following family Members 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 26.
- **Child with a Disability**: A child who reaches the age of 26 is eligible to continue enrollment if the child meets the following eligibility criteria:

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

- **Domestic Partner**: An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but isn't married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace, Molina, 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 Marketplace and submit any required application(s), forms and requested information for the Dependent. A Member's request to enroll a new Dependent must be submitted to the Marketplace within 60 days from the date the Dependent became eligible to enroll in the Plan.

- **Child Born Out of Wedlock**: Molina Healthcare will not deny enrollment of a child under this Agreement if the child's parent is covered under this Agreement on the grounds that the child 1) was born out of wedlock; 2) is not claimed as a dependent on the parent's federal tax return; or 3) does not reside with the parent or does not reside in Molina's 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, placement for adoption, child support, or other court order.
    - The Child gains status as a citizen, national, or lawfully present individual
    - The Child permanently moves into the service area.

- **Court Order to Provide Child Coverage**: When a parent/guardian is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage under this EOC, Molina shall:

    - Permit the eligible parent/guardian to enroll, in the family coverage under this EOC, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
    - If the eligible parent/guardian is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program.
    - And, not disenroll or eliminate coverage of the child unless Molina is provided satisfactory written evidence that: (a) the court or administrative order is no longer in effect; or (b) the child is or will be enrolled in comparable health coverage through another health insurer or health care program that will take effect not later than the effective date of disenrollment. However, in no event may Molina Healthcare disenroll or eliminate coverage of the child if such action is not permitted by applicable law.

- **Foster Child**: A newly foster child or child placed with You or Your Spouse for foster care is covered from whichever date is earlier:

    - The date of placement in foster care.
    - The date You or Your Spouse gain the legal right to control the child's health care.

If You do not enroll the foster child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days. This includes the date of placement in foster care or when the legal right to control the child's health care was gained, whichever is earlier. For purpose of this requirement, “legal right to control health care” means You or Your Spouse have:

- A signed written document. This can be:

    - a health facility minor release report
    - a medical authorization form, or
    - a relinquishment form or
    - Other evidence that shows You or Your Spouse has the legal right to control the child's health care.

Proof of the child’s date of birth or qualifying event will be required.

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

Please note: claims for newborns for eligible Covered Services will be processed as part of the mother’s claims and any Deductible or OOPM amounts satisfied through the processing of such a newborn’s claims will accrue as part of the mother’s Deductible and OOPM. However, if an enrollment file is received for the newborn during the first 31 days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn’s claims, and any Deductible or OOPM amounts satisfied through the processing of these claims will accrue as part of the

newborn's individual Deductible or OOPM (i.e. not under the enrolled mother's Deductible and OOPM).

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

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

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

PREMIUM PAYMENT

To establish 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 that month (this is the "Due Date"). Molina will send a Subscriber a written notification informing them of the amount due for coverage for the upcoming month in advance of the Due Date.

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

Payment: Molina accepts Premium Payments online, by phone, by mail, and through money order. Please refer to the Molina Marketplace website 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 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 short period after a Member's Premium Payment is due and has not been paid in full. If a Subscriber hasn't made payment, they may do so during the Grace Period and avoid losing their coverage. The length 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 advance payments of the premium tax credit (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.(Local 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 31 day consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an advance payment of the premium tax credit (APTC). The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. (Local 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 and their Dependents informing them when their Membership ended due to non-payment of Premiums. Members may appeal a termination decision by Molina. Please refer to the Molina Marketplace website, the Appeals and Grievances section of this document, 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 Marketplace.

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

eligible claims that were previously denied as a result of that nonpayment will be reprocessed for payment.

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

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not covered with Molina. Coverage for a former Member ends at 11:59 p.m. (Local 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 30 days. Molina and its Providers will not have any further liability under this Plan. In the case of fraud, Molina may retain portions of this amount in order to recover losses due to the fraud. Molina may terminate or non-renew a Member for any of the following reasons:

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

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by the Marketplace and Molina. The Marketplace will send the Member notification of loss of eligibility. In addition, Molina will send a termination notices and 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. (Local 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. (Local 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 Marketplace. The Marketplace 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 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 180 calendar days prior to the date the coverage will be discontinued.

CONTINUITY OF CARE

Members receiving an Active Course of Treatment for Covered Services from a Participating Provider whose participation with Molina is ending.

When Molina terminates or suspends any contract with a Participating Provider, Molina shall notify, in writing, affected covered Members who are current patients of or, where applicable, assigned to the provider, within 30 days. The notice to covered Members shall advise them of their right to continue receiving care from the provider as set forth in 13.10.23.13 NMAC. Current patients are covered Members who have a claim with Molina related to the provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

- Molina shall assist such affected covered Members in locating and transferring to another similarly qualified provider.
- A covered Member may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered Member, if the covered Member has not received comparable notice during this time from the provider.

The Member may have a right to continue receiving Covered Services from that provider until the Active Course of Treatment is complete or for 90 days, whichever is shorter, at in-network Cost Sharing. An Active Course of Treatment is:

- An ongoing course of treatment for a “Life-Threatening Condition,” which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
- An ongoing course of treatment for a Serious Acute Condition, which is a disease or condition requiring complex ongoing care which the covered person

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

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

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

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

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

- Molina will only extend coverage for Covered Services to Non-Participating Providers when it is determined to be Medically Necessary, through Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.
- Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina) may be responsible for coverage until a Member's coverage is effective with Molina.
- After a Member's effective date with Molina, Molina may coordinate the provision of Covered Services with any Non-Participating Provider on a Member's behalf for

transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

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

Access To Care

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

24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is 1 (888) 275-8750

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

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

To locate a Participating Provider, please refer to the provider directory at MolinaMarketplace.com or call Customer Support to request a hard copy. Molina will provide an updated provider list biennially, pursuant to 13.10.23.8D NMAC

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

Member Right to Obtain Healthcare Services Outside of Policy: 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. However, Members will be 100% responsible for payment for such services and the payments for such services will not apply to their Deductible or OOPM for any of services under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement.

Primary Care Provider (PCP): A Primary Care Provider (or PCP) takes care of routine and basic health care needs. PCPs provide Members with services such as physical exams, immunizations, or treatment for an illness or injury that is not needed on an urgent or emergency basis. Molina asks Members to select a PCP from the provider directory. 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 he or she can take care of right now.

Telehealth Services: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. Covered Services are also available through Telehealth, except as specifically stated in this Agreement. 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. Molina covers services appropriately delivered through telehealth on the same basis and to the same extent that Molina covers the same service through an in-person provider visit. The following additional provisions apply to the use of Telehealth services:

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

No Participating Provider to Provide a Covered Service: If there is no Participating Provider that can provide a non-Emergency Medically Necessary Covered Service, Molina will provide the Covered Service through a Non-Participating Provider in the same manner

as and at no greater cost than the same Covered Services when rendered by Participating Providers. Prior Authorization is required before the initiation of the service.

A Member shall not be held liable for payment of services if a Participating Provider mistakenly makes a referral to a Non-Participating Provider, unless Molina has notified the Member in writing concerning the use of Non-Participating Provider and informed the Member that Molina will not be responsible for future payment to the 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 Customer Support to request reasonable accommodation assistance

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

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

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

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

PRIOR AUTHORIZATION

Some services and 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. The following services always require authorization:

- Hospital/outpatient stay (non-emergency)
- Surgery
- Medical equipment and supplies

- In addition the following services require Prior Authorization: Admission in a hospital or ambulatory care center for dental care.
- All inpatient admissions
- Any kind of wheelchair
- Bariatric surgery
- Certain Ambulatory Surgery Center service (ASC)*
- Certain Durable Medical Equipment*
- Certain injectable drugs And medications not listed on the Molina Drug Formulary*
- Certain outpatient hospital service*
- Cosmetic, plastic and reconstructive procedures (in any setting)
- Custom orthotics, custom prosthetics, and braces. Examples are:
    - Shoes or shoe supports
    - Special braces
- Drug quantities that exceed the day-supply limit
- Experimental and Investigational procedures
- Gene therapy – (most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies subject to Prior Authorization)
- Genetic counseling and treatment
- General anesthesia for dental care in Members 5 years old or older
- Habilitative Services – After 1 evaluation and 24 visits in an outpatient setting
- Hearing Aids
- Home health care - After 7 visits
- Hyperbaric Therapy
- Imaging and special tests Examples are:
    - CT (computed tomography)
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiogram)
    - PET (positron emission tomography) scan
    - Digital breast tomosynthesis (3D mammography)
- Implanted hearing device
- Low vision follow-up care
- Mental Health Services*
    - Electroconvulsive Therapy (ECT),
    - Mental Health Inpatient,
    - Neuropsychological and psychological testing,
    - Transitional substance abuse residential treatment
    - Partial hospitalization
- Pain management care and procedures, except trigger point injections
- Pregnancy and delivery (notification only)
- Radiation therapy and radio surgery
- Rehabilitative services
    - Cardiac and pulmonary rehabilitation
    - Occupational Therapy (After initial evaluation and 23 visits/year in outpatient and home settings)
    - Physical Therapy (After initial evaluation and 23 visits/year in outpatient and

home settings)
    - Speech Therapy (After 6 visits for outpatient and home settings)
- Scooters
- Services Rendered by a Non-Participating Provider
- Sleep Studies (except home sleep studies)
- Certain specialty pharmacy drugs (oral and injectable)
- Substance Abuse Services:
    - Inpatient Services
    - Partial hospitalization
    - Detoxification Services
    - Transitional substance abuse residential treatment
- Surgery or other procedures to correct diagnosed infertility. This is subject to "Exclusions" from coverage.
- Transplant evaluation and related service including Solid Organ and Bone Marrow (Cornea transplant does not require a Prior Authorization)
- Transportation. This is for non-emergent ground and air ambulance. Must be medically necessary. Examples are a special vans service or ambulance.
- Unlisted and miscellaneous medical codes or any other services listed as needing Prior Authorization in this EOC.
- Wound Therapy

***Call Molina's Customer Support Center at 1 (888) 295-7651. If You need to find out if, Your service needs Prior Authorization.**

Molina will decide about authorization for a service within 14 calendar days after receiving the request and all medical information necessary to decide and in accordance with state and federal statutes. Providers may request that Molina expedite the authorization process if the standard process would risk the Member's health. Molina will notify the Provider about the decision at the conclusion the approval process, within timeframes required by State and Federal law. If the request for service is not approved by Molina, the Member will be notified, including rights about how to appeal the denial. Prior authorization requirements for Covered Services are subject to change, and Members should contact the Customer Support Center of visit the Molina Marketplace website prior to receiving services.

Authorization Decision Timeframes

Medical Services:

- **Routine Prior Authorization Requests:** Will be processed within five (5) business days from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination, and no longer than seven (7) calendar days from the initial receipt of the request.

- **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 are processed within twenty-four (24) 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.
- **Gynecological or obstetrical ultrasound procedures**: Do not require Prior Authorization.

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.” Prior Authorizations use uniform prior authorization forms for prescription drug prior authorization protocols as required by State Law.

Medical Necessity: Prior Authorization determinations are made based on a review of Medical Necessity for the requested service. Molina is here to help. If a Member has questions about how a certain service may be approved, call Customer Support. Molina can explain how that type of decision is made. The number is 1 (888) 295-7651. TTY users may dial 711.

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.

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.

Utilization Review: Licensed Molina staff processes Prior Authorization requests and conducts. Upon request in writing or by telephone, Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations by mail, fax, or call by Molina. Molina provides help and alternatives for care when a member is not authorized for a service.

Inpatient Concurrent Review: Molina conducts concurrent review on inpatient cases. For non-emergency admissions, a Member, their Provider, or the admitting facility will need to request precertification at least 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.

Referral: A Members PCP may send the Member to another Provider for a specific Covered Service. This process is a Referral. A Referral is needed for some services before they will be covered.

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

COORDINATION OF BENEFITS (COB)

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

Definitions:

A. Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced

because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

6. 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.

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

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

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

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

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

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

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

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

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

benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan: A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. This plan as Secondary will pay to the extent necessary to meet ligations as secondary carriers under the regulations established by the superintendent, health maintenance organizations shall make payments for services that are: (1) received from non-participating providers; (2) provided outside their service areas; or (3) not covered under the terms of this Agreement. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

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

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

has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

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

If You believe that we have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaints" section, below. If You are still not satisfied, You may call The New Mexico Office of Superintendent of Insurance for instructions on filing a consumer complaint. Call 1-855-4ASK-OSI (1-855-427-5674), or visit The New Mexico Office of Superintendent of Insurance website at www.osi.state.nm.us.

COST SHARING

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

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

COVERED SERVICES

This section describes the Covered Services available with this Plan. Covered Services are available to current Members and are subject to Cost Sharing, exclusions, limitations, authorization requirements, approvals and the terms and conditions of this Agreement. Molina will provide 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 or by under state and federal statutes;
- The Member receives Covered Services from a Participating Provider, except for Covered Services that are expressly covered when rendered by non-Participating Providers under the terms of this Agreement.

Members should read this Agreement completely and carefully in order to understand their coverage and to avoid being financially responsible for services that are not Covered Services 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 implementing regulations. Services that are not EHBs will be specifically described in this Agreement. EHB coverage includes at least the 10 categories of benefits identified in the ACA and its implementing regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. However, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. (Local Time) on the last day of the month that they turn age 19. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage. Under the ACA and its implementing regulations governing EHBs:

- Molina is not allowed to set lifetime limits or annual limits on the dollar value of EHBs provided under this Agreement.
- When EHB preventive services are provided by a Participating Provider, the Member will not have to pay any Cost Sharing 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. Such Cost Sharing includes Deductibles, Coinsurance and Copayments, but excludes Premiums and Member spending on non-Covered Services.

Acupuncture Services: Molina covers acupuncture diagnostic and treatment services when provided for Habilitative and Rehabilitative services only, when furnished by licensed Participating Providers and appropriate for the treatment of the Member's conditions. Coverage includes complimentary acupuncture services without Prior Authorization for specified medical conditions. Coverage does not include any maintenance therapy Cost Sharing applicable to outpatient services will apply.

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

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

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

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

- The investigational item, device or service itself,
- Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and
- Any service inconsistent with the established standard of care for the patient's diagnosis.

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

Autism Spectrum Disorder: Molina cover the following services for the diagnosis and treatment of Autism Spectrum Disorder:

- Well baby and well child screening for diagnosing the presence of autism spectrum disorder.
- Speech therapy, occupational therapy, physical therapy, and applied behavioral analysis.

To be covered under this EOC, treatment for Autism Spectrum Disorder must be:

- Medically Necessary;
- Prescribed by a physician who is a Participating Provider; and
- Provided under the Participating Provider's treatment plan.

This plan includes:

- Diagnosis;
- Proposed treatment by types;
- Frequency and duration of the treatment;
- Anticipated outcomes stated as goals;
- Frequency with which the treatment plan will be updated;
- Signature of the treating physician.

Benefits for the diagnosis of Autism Spectrum Disorder and for Covered Services under an approved treatment plan must be received from appropriate Participating Provider health care professionals. Outpatient Office Visit Cost Sharing will apply.

Coverage for Autism Spectrum Disorder shall not be denied on the basis that the services are habilitative or rehabilitative in nature. (This means that the services are treatment programs that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual.)

We do not cover treatment or services for Autism Spectrum Disorder when they are received under the Federal Individuals with Disabilities Education Improvement Act of 2004 (IDEA). We also do not cover treatment or services under specialized educational programs (for children ages 3 to 23) that are the responsibility of state and local school boards.

For the purposes of this section, the term **"Autism Spectrum Disorder"** means a condition that meets the diagnostic criteria for the pervasive developmental disorders

published in the Diagnostic and Statistical Manual of Mental Disorders, also known as DSM-V-TR, current edition, text revision. This is published by the American psychiatric association ‘This includes autistic disorder; Asperger’s disorder; pervasive development disorder not otherwise specified; Rett’s disorder; and childhood disintegrative disorder.

Bariatric Surgery (limited to one per lifetime): Molina covers hospital inpatient care related to bariatric surgical procedures. This includes room and board, imaging, laboratory, special procedures, and Participating Provider physician services. Included services are those performed to treat morbid obesity. Treatment means changing the gastrointestinal tract to reduce nutrient intake and absorption, all of the following requirements must be met to receive these services:

- Complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes. These changes are necessary for long-term bariatric surgery success.
- A Participating Provider physician who is a specialist physician in bariatric care determines that the surgery is Medically Necessary.

For Covered Services related to bariatric surgical procedures, the Member will pay the Cost Sharing the Member would pay if the Covered Services were not related to a bariatric surgical procedure. For example, for hospital inpatient care, the Member would pay the Cost Sharing listed under “Inpatient Hospital Services” in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

Molina will cover only one bariatric surgery for the Member during Your lifetime.

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

- Preventive screening and testing (please refer to the Preventive Services section of this Agreement for full details)
- 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 (not less than 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection 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
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for full details)
- Skin cancer behavioral counseling (age 6 months to 24 years)

Chiropractic Services: Chiropractic diagnostic and treatment services are covered when furnished by licensed Participating Providers and appropriate for the treatment of the member's conditions. Coverage for chiropractic care is limited to 20 visits in each calendar year, unless for habilitative or rehabilitative purposes.

Circumcision of Newborn Males: Circumcision of newborn males whether the child is the Member's newly born natural, adopted children, or foster children.

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

- Dental services for radiation treatment
- Dental anesthesia
- Dental and Orthodontic services for Cleft Palate
- Services to treat Temporomandibular Joint Syndrome (TMJ) (Please refer to the Temporomandibular Joint Syndrome section of this Agreement)
- Dental services needed due to accidental injury
- Other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary

Molina does not provide pediatric dental services under this Agreement.

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

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

- Diabetes education and self-management
- Diabetes (Type 2) screening

- Screening for gestational diabetes
- Dietician services
- Nutritional counseling

For information regarding Diabetes Supplies, please refer to the “Prescription Drug” section.

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

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

Durable Medical Equipment: This plan covers equipment that meets the following standards: Equipment that is medically necessary for the treatment of an illness of accidental injury or to prevent further deterioration. Equipment must be designed for repeated use, including oxygen equipment, functional wheelchairs, and crutches. Equipment that is considered standard and/or basic as defined by nationally recognized guidelines.

Covered orthotic appliances including:

- Podiatric appliances for prevention of feet complications associated with diabetes.
- Braces and other external devises used to correct a body function including clubfoot deformity.

Limitations on orthotic appliances: Foot orthotics or shoe appliances are not covered, except for our members with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for members in accordance with nationally recognized guidelines. Orthotic appliances may be limited to a calendar year maximum. Covered prosthetic devises. Prosthetic devices are artificial devises that replace or augment a missing or impaired part of the body.

The purchase, fitting, and necessary adjustments of prosthetic devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are covered when they replace a limb or other part of the body, after accidental or surgical removal and/or when the bodys growth necessitates replacement.
Examples of prosthetic devices include, but are not limited to:

- breast prostheses when required because of mastectomy and prophylactic mastectomy
- artificial limbs
- prosthetic eye
- prosthodontic appliances
- penile prosthesis
- joint replacements
- heart pacemakers
- tracheostomy tubes and cochlear implants

Repair and replacement of durable medical equipment, prosthetics and orthotic devices must comport with state law. Repair and replacement is covered when medically necessary due to chance in the members condition, wear or after the products normal life expectancy has been reached. One-month rental of a wheelchair is covered if the member owned the wheelchair that is being repaired.

EMERGENCY SERVICES

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

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

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

Important: Except as otherwise required by State Law, when Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, claims for Emergency Services will be paid at Molina's Allowed Amount.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina reserves the right to require a transfer to a Participating Provider facility once the Member has stabilized sufficiently. If Molina requires a transfer, Molina will work with the Member and

their Provider to provide transportation to a Participating Provider facility. If the Member's coverage terminates during a Hospital stay, the services received after the termination date are not Covered Services.

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

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

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

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

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

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

Emergency Medical Transportation: Emergency medical transportation (ground and air ambulance), or ambulance transport services provided through the 911 emergency response system are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. Covered emergency medical transportation services will be provided at the cost share identified within the Summary of Benefits and Coverage (SBC), up to the lesser of Molina's Allowed Amount for such services.

Family, Infant and Toddler (FIT) Program: Molina provides coverage to Dependent children, from birth through three years of age, who qualify for services through the Family, Infant, and Toddler (FIT) Program. The FIT Program is administered by the New Mexico Department of Health. The program provides intervention services for children who have or are at risk for early developmental delays and/or disabilities. Molina covers Medically Necessary early intervention services provided as part of an individualized family plan to Dependent children who are enrolled in the FIT Program with the New Mexico State Department of Health. They must receive such services from designated and approved FIT Program providers. Coverage and services are provided as defined in the requirements for the FIT Program Early Intervention Services under New Mexico law.

The maximum benefit is $3,500 per Dependent and enrolled child during each calendar year. Outpatient Office Visit Cost Sharing will apply.

No payments under this section are applied to any maximums or annual limits under this Agreement.

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

-
    - Diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated
    - Prescription birth control supplies, including emergency birth control supplies when filled by a Participating Provider pharmacist, or by a Non-Participating Provider in the event of an Emergency
    - Follow-up care for any problems Members may have using birth control methods issued by the family planning providers
    - Laboratory tests if medically indicated as part of deciding what birth control methods a Member might want to use
    - Limited history and physical examination
    - 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.

Molina is compliant with Health Resources and Services Administration (HRSA) guidelines and include all Food and Drug Administration (FDA) -approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with

reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services).

Contraceptives are provided for up to a six month supply. In addition, as noted in the Preventive Services for Adults and Seniors section of this document, there is no cost-sharing to You for covered contraceptives. Additionally, Molina does not impose utilization review, prior authorization or step therapy requirement nor do We have other restrictions on coverage for covered contraceptives.

The 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;
- Diaphragm;
- Sponge;
- Cervical cap;
- Female condom;
- Spermicide;
- Emergency contraception (Plan B/Plan B One Step/Next Choice); and
- Emergency contraception (Ella).

Habilitation Services: Molina covers healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aids for Dependent Children: Molina covers hearing aids and certain related services for Dependent children. They must be under 18 years of age. They may be under 21 years of age, if still attending high school. Coverage includes one hearing aid for qualifying Dependent children every 36 months of coverage under this EOC. A hearing aid that costs $2,500 or less is covered at No Charge. A member may choose a hearing aid for a Dependent child that costs more than $2,500. A member may purchase a hearing

aid more frequently than once every 36 months. However, a member will pay the excess cost at the Coinsurance Cost-Share indicated on the Summary of Benefits. Dollar amount limits are not applicable to hearing aids for Habilitative or Rehabilitative purposes. These amounts will be counted toward the member's Deductible and Your Out-of-Pocket Maximum under this EOC.

Hearing aid coverage includes fitting and dispensing services. This includes providing ear molds as necessary to maintain optimal fit. Services must be provided by a Participating Provider audiologist, hearing aid dispenser, or physician.

Hearing Screenings: Molina covers routine hearing screenings for Members age 18 or younger when performed by a licensed, qualified Participating Provider. These services are provided at no charge.

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

- In-home medical care services
- Home health aide services
- Medical social services
- Medical supplies
- Necessary medical appliances
- Nurse visits and part-time skilled nursing services
- Physical, occupational, speech or respiratory therapy
- Covered Drugs prescribed by an In-Network Provider for the duration of Home Health Care Services.

Home healthcare services are covered under this Agreement:

- Up to four hours per visit for visits by a nurse, medical social worker, physical, occupational, speech therapist, or a home health aide
- Up to 100 visits per calendar year (counting all home health visits)

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

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

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

Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services: Molina covers laboratory, radiology (including X-ray) and scanning services at a Participating Provider. Covered scanning services can include CT Scans, PET Scans, MRI, and Digital breast tomosynthesis (3D mammography) with Prior Authorization. Molina will help 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 when provided by Participating Providers and facilities acting within the scope of their license. Except for involuntary admissions, all inpatient admissions, and certain outpatient services require Prior Authorization. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria.

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

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

intellectual disability. 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 Participating Provider facility:

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

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. Medically Necessary determinations will be made by Molina in consultation with the provider. 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: Testing and treatment of phenylketonuria (PKU) and other inborn errors of metabolism that involve amino acids is covered. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. The health care professional will consult with a 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.

For purposes of this section, the following definitions apply: “Formula” is an enteral product for use at home that is prescribed by a Participating Provider.

“Special food product” is a food product that is prescribed by a Participating Provider for treatment of PKU. It may also be prescribed for other inborn errors of metabolism. It is used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.
(Durable Medical Equipment (DME) Cost Sharing will apply)

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

- Office visits, including:
    - Associated supplies
    - Pre and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician’s office, an outpatient or an inpatient setting. Services are subject to either outpatient facility or inpatient facility Cost Sharing.
- Diagnostic procedures including:
    - Bone density studies
    - Clinical laboratory tests
    - Colonoscopies (colonoscopies include removal of polyps during the procedure this is at no cost sharing to the member)
    - Cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
    - Gastrointestinal lab procedures
    - Pulmonary function tests
    - Sleep disorder studies
- Radiation therapy
- Routine pediatric and adult health exams
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Covered dependents have direct access to obstetrical and gynecological care.

- Sleep studies (Prior Authorization is required, except for home sleep studies. Separate facility Cost Sharing may apply)
- Audiology and hearing tests
- Consultations and well child care
- Diabetic eye examinations (dilated retinal examinations)
- Diagnosis and medically indicated treatments for physical conditions causing infertility (Benefit covers only testing, diagnosis, and corrective procedure, subject to exclusions in the “Exclusions” section.)
- Human Papillomavirus (HPV) vaccine is covered for females aged 9-14
- Injections, allergy tests and treatments when provided by Your PCP
- Osteoporosis services for women (including treatment and appropriate management when such service are determined to be Medically Necessary by the women’s PCP, in consultation with Molina)
- Outpatient maternity care (including complications of pregnancy and Medically Necessary at home care)
- Outpatient newborn care
- Physician and other Practitioner care in or out of the hospital
- Prevention, diagnosis, and treatment of illness or injury
- Routine pediatric and adult health exams
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye. (Benefits are not available for charges connected to routine refractive vision examinations or to the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, “Pediatric Vision Rider.”)
- Specialist consultations (for example, a heart doctor or cancer doctor)

Complex Case Management: Living with health problems can be hard. Molina has a program that can help. The Complex Case Management program is for Members with difficult health problems. It is for those who need extra help with their health care needs.

The program allows the Member to talk with a nurse about the Member's health problems. The nurse can help the Member learn about those problems. The nurse can teach the Member how to manage them. The nurse may also work with the Member's family or caregiver to make sure the Member gets the care they need. The nurse also works with the Member's doctor. There are several ways the Member can be referred for this program. There are certain requirements that the Member must meet. This program is voluntary. The Member can choose to be removed from the program at any time.

If the Member would like information about this program, please call the Customer Support Center toll free.

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

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia;
- Laboratory services
- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that Members or Member's provider notifies Molina.
- When necessary to protect the life of the infant or mother, Molina covers transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility as defined by state law. Prenatal care includes medically necessary nutritional supplements prescribed by the expectant mother's obstetrician-gynecologist, or other approved health care professional from whom the expectant mother is receiving prenatal care.
- Alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

After talking with a Member, 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. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is

shortened, then at least 3 home care visits will be provided. 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 provided in an inpatient or outpatient hospital setting require Prior Authorization.

Preventive Services: Under 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: uspreventiveservicestaskforce.org. The list in the section is subject to change visit the website for the most up-to-date information.
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, those preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

- Preventive Services for Children and Adolescents: The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay Cost Sharing if services are furnished by a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider. Please consult with your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for:

- Alcohol and Drug Use assessments for adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Autism screening for children
- Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Basic vision screening (non- refractive)
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Behavioral health assessment for children
- Cervical dysplasia screening: sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21.These include those with special health care needs.)
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Health management
- Hearing screening
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*
- Initiation Prevention and Cessation of Tobacco Use: Primary Care Interventions for Children and Adolescents who have not started to use tobacco.
- Iron supplementation in children when prescribed by a Participating Provider
- Lead blood level testing (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.)

- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

*If You take Your child to Your local health department, or the school has given Your child any shot(s), make sure to give a copy of the updated shot record (immunization card) to Your child's PCP.

- Preventive Services for Adults and Seniors: The following outpatient preventive care services are covered and recommended for all adults, including seniors. You will not pay any Cost Sharing if You receive services from a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider. Please consult with your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for:

  - Abdominal aortic aneurysm screening: for male former smokers age 65-75
  - Alcohol misuse counseling
  - Anemia screening: women
  - Aspirin for the prevention of preeclampsia
  - Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
  - Bacteriuria screening: pregnant women
  - Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
  - Blood pressure screening
  - BRCA counseling about breast cancer preventive medication
  - Breast cancer and chemoprevention counseling for women at high risk
  - Breast exam for women (based on Your age)
  - Breastfeeding support, supplies counseling

- Cancer screening
- Cholesterol check
- Chlamydial infection screening: women
- Colorectal cancer screening (based on Your age or increased medical risk. Examples of this screening include colonoscopy, and medically necessary periodic stool examinations.)
- Cytological Screening (pap smear) as determined by the health care provider in accordance with national medical standards, for women who are eighteen years of age or older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening. The coverage shall make available human papillomavirus screening once every three years for women aged thirty and older.
- Cytologic screening in a hospital or certified lab for the presence of cervical cancer
- Depression screening: adults
- Depression screening: Postpartum women
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling: adults at higher risk for chronic disease
- Dietary evaluation and nutritional counseling
- Exercise to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Healthy diet counseling
- Hearing screenings
- Hepatitis B screening: pregnant women
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations

- Medical history and physical exam
- Obesity screening and counseling: adults
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention
- Prostate specific antigen testing
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection and pregnant women.
- Screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years of age or in persons at high risk for infection
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram biennially for persons of age 50 and over.)
- Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
- Screening for osteoporosis for women age 65 years and older
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Statin preventive medication: adults age 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions

    - Screening for tobacco use; and,

- For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

    - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

- Tuberculosis (TB) screening
- Unhealthy Drug Use: Screening for Adults 18 years and older
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed).

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. As new recommendations and guidelines for preventive services are published and recommended by the government sources 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 product 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 implementing regulations and applicable State Law.

Please consult with your PCP to determine whether a specific service is preventive or diagnostic.

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

- Cochlear implants
- Hip joints
- Intraocular lenses
- Osseointegrated hearing devices

- Pacemakers

External devices:

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

Coverage is dependent on all the following requirements being met:

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

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

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

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

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

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider specializing in reconstructive surgery, offers only a minimal improvement in appearance

- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical, speech and occupational therapy services in a variety of inpatient and/or outpatient settings. Molina covered service include short-term for physical therapy and occupation therapy, provided in a rehabilitation facility, skilled nursing facility, home health agency, or outpatient setting. Rehabilitation services are up to 35 visits per calendar year which includes covered services with a chiropractor. The chiropractor must provide services in connection with outpatient rehabilitation, occupational therapy and physical therapy.

Skilled Nursing Facility: Molina covers 60 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

Smoking Cessation: Molina's care management team works directly with members, at their request, to assist with the most appropriate action based upon the member's needs, including determine the frequency, method, treatment, or setting for the recommended item or services. Determinations of services will be made by Molina in consultation with the provider. Molina Member's are always given access to at least one of the tobacco cessation products without prior authorization and are consistent with all state and federal laws.

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

- Day-treatment programs
- Individual and group substance abuse counseling
- Individual substance abuse evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Molina does not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this Agreement. Nonmedical transitional residential recovery and substance use disorder services do not include therapy or counseling for any of the following: career, marriage, divorce, parental, behavioral, job, learning disabilities, and intellectual disability.

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

Inpatient surgical services include

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

Outpatient surgery services provided in any of the following locations:

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

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

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

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

Covered Services for TMJ are limited to:

- One surgical procedure per calendar year; and
- Three visits per calendar year for:

- Medically Necessary medical non-surgical treatment of TMJ, including coverage for prescribed intraoral splint therapy devices;
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed.

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

- Human Solid Organ transplant benefits are Covered for:
    - Kidney
    - liver
    - pancreas
    - intestine
    - heart
    - lung
    - multi-visceral (3 or more abdominal Organs)
    - simultaneous multi-Organ transplants - unless investigational
    - pancreas islet cell infusion.
- Meniscal Allograft
- Autologous Chondrocyte Implantation knee only
- Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are Covered for the following indications:
    - multiple myeloma
    - leukemia
    - aplastic anemia
    - lymphoma
    - severe combined immunodeficiency disease (SCID)

- Wiskott Aldrich syndrome
- Ewings Sarcoma
- germ cell tumor
- neuroblastoma
- Wilms Tumor
- myelodysplastic Syndrome
- myelofibrosis
- sickle cell disease
- thalassemia major

If there is a living donor that requires surgery to make an Organ available for a Covered transplant for our Member, Coverage is available for expenses incurred by the living donor for surgery, laboratory and X-ray services, Organ storage expenses, and Inpatient follow-up care only. We will pay the Total Allowable Charges for a living donor who is not entitled to benefits under any other health
benefit plan or policy.

Limited travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be Covered for both out-of-state and in-state, up to a maximum of $150 per day for the transplant recipient, live donor and one other person combined. Benefits will only
be Covered for transportation, lodging and meals and are limited to a lifetime maximum of $10,000.

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

Vision Services (Adult and Pediatric): Molina covers, for all Members, diabetic eye examinations (dilated retinal examinations) once 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, when provided by a Participating Provider on plans with Adult vision benefits

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

Laser corrective surgery is not covered.

Adult vision is only on selected plans, please refer to your Summary of Benefits.

PRESCIRPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Molina covers drugs ordered by Providers, approved by Molina, and filled through a pharmacy that is a Molina contracted pharmacy. Covered drugs include over-the-counter (OTC) and prescription drugs. Molina also covers 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 120 days based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs. Molina will send the Member notice 60 days prior to formulary changes in accordance to state law.

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

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

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

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

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

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

Note: if Molina fails to respond within 72 hours, the request is deemed to be approved.

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	Non-Preferred Generic drugs and 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 preventative service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 cost sharing.
DME	Durable Medical Equipment ("DME")- cost sharing applies; some non-drug products on the Formulary have cost sharing determined by the DME coinsurance.

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

Over-the-Counter Drugs and Supplements: Molina covers over-the-counter drugs and supplements in accordance with State Law and Federal laws.

Durable Medical Equipment (DME): Molina will cover DME rental or purchase costs for use with certain drugs when obtained through a contracted vendor. Molina will also cover reasonable repairs, maintenance, delivery, and related supplies for DME. Members may be responsible for necessary DME repair or replacement costs if needed due to misuse or loss of the DME. Prior Authorization may be required for DME to be covered. Coverage will be under the medical benefit or the pharmacy benefit, depending on the type of DME. Please refer to the Formulary for DME and other non-drug products covered under the pharmacy benefit. Please refer to 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, including those for the legally blind insulin injection aids, including those adaptable to meet the needs of the legally blind prescriptive oral agents for controlling blood sugar levels glucagon emergency kits, continuous glucose monitoring DME, blood glucose test strips, urine test strips, and select pen delivery systems for the administration of insulin.

Diabetic Drug limits: The amount a Member with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars ($25.00) per thirty-day supply.

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

Day Supply Limit: While Providers determine how much drug, product supply, or supplement to prescribe, Molina may only cover one month of supply at a time for certain products. The Formulary indicates “MAIL” for items that may be covered with a 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, the Member request or agrees requests or agrees to receive less than a thirty-day supply of the prescription drug, the reduced fill or refill is made for the purpose of synchronizing the

Member's prescription drug fills. 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 (including oral 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.

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 Sections 59A-22-42, 59A-22-43, and 59A-46-44 NMSA 1978. 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
- Gene therapy
- Experimental and Investigational drugs

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

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

EXCLUSIONS

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

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

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

- Required for obtaining or maintaining employment or participation in employee programs
- Required for medical coverage, life insurance coverage or licensing, or
- On court order or required for parole or probation.

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

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

Dietitian: A service of a Dietitian is not a covered service except as specifically covered under the Dietician Services or Hospice Care benefits. Please see both sections for additional information.

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

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

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

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

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

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

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

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

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

- Vocational training or teaching vocational skills
- Professional-growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy
- Examinations related to job, athletic (sports physicals), or recreational performance

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

Massage Therapy: Massage therapy is not covered.

Non-Emergent Services Obtained in an Emergency Room: Services provided within an emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered. This does not apply to person who, possessing an average knowledge of health and medicine, seeks medical care for what reasonably appears to be an acute condition that requires medical attention, even if the patients' condition is subsequently determined to be non-emergent.
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. This exclusion does not apply to formulas and special food products when prescribed for the treatment of Phenylketonuria or other inborn errors of metabolism involving amino acids, in accordance with the" Phenylketonuria (PKU)" section of this Agreement.

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.

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

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

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

- A Hospital,
- A skilled nursing facility,
- Inpatient respite care covered in the Hospice Care section,

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

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

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

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

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

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

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

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

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

Vision Care Services: Molina does not cover the following:

- Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses
- Eye exercises, visual training, orthoptics, sensory integration therapy
- Radial keratotomy, laser surgeries, and other refractive keratoplasties
- Refractions (tests to determine if eyeglasses are needed, and if so, what prescription)

CLAIMS

Provider 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 Provider to Molina within 365 calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and Provider has been furnished with the correct name and address for Molina. If Molina is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to Molina within 30-45 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to Molina within these timelines are not be eligible for payment and Provider waives any right to payment.

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract, State Law and Federal Law. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, generally Molina will pay the Provider of service within 45 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements.

Member Filing a Claim (Forms): Molina Healthcare, upon receipt of a notice of Claim from a Member, will furnish to the Member such forms as are usually furnished by Molina Healthcare for filing proofs of loss (if such additional forms are appropriate and required by Molina) with respect to such Claims. If Molina Healthcare does not furnish such required forms to the Member within 15 days after the notice of Claim has been given to Molina, the Member shall be deemed to have complied with the requirements of this EOC as to proof of loss upon submitting, within the time fixed by this EOC for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which Claim is being made.

Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was approved or does not require approval, Molina will repay the Member. The Member must submit the claim for reimbursement within 12 months from the date they made the payment. Members must mail this information to Molina Customer Support at the address on the inside cover of this Agreement. The Member will need to mail Molina a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required

Indemnities payable under this Agreement for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof.

If the bill is for a prescription, the Member will need to complete a Reimbursement Form found in the Pharmacy section of the Molina website. Include a copy of the prescription label and pharmacy receipt when submitting this form to the address as instructed in the form. After Molina receives the request for reimbursement, Molina will respond to the Member within 30 calendar days. If the claim is accepted, Molina will mail a check. 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 Summary of Benefits for their Cost Sharing responsibilities for Covered Services. Members may be liable to pay full price for services when:

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

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

Acceptance of certain third party payments: Molina accepts premium and cost-sharing payments from the following third-party entities from plan enrollees as required by state law:

- A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
- An Indian tribe, tribal organization, or urban Indian organization; and
- A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

Payment of Claims for Deceased Member: Claims submitted by a Member for Covered Services received by a deceased Member (when such Member was living) will be payable in accordance with the beneficiary designation and the provisions respecting such payments. If no such designation or provision is provided, Claims will be payable to the estate of the deceased Member. Any other Claims unpaid at the Member's death may, at Molina's option, be paid to the beneficiary. All other Claims will be payable to the Member or to the health care provider, at the option of Molina Healthcare.

LEGAL NOTICES

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

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

Renewability of Coverage: Molina will renew coverage for Members on the first day of each month if all Premiums which are due have been received. Renewal is subject to

Molina's right to amend this Agreement and the Member's continued eligibility for this Plan. Members must follow all procedures required by the Marketplace to redetermine eligibility and guaranteed renewability for enrollment every year during the Open Enrollment Period.

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

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

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

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

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

New Mexico contacts for the Managed Health Care Bureau and the State of New Mexico Office of the Attorney General as follows:

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
www.osi.state.nm.us

State of New Mexico Office of the Attorney General
408 Galisteo Street
Villagra Building

Santa Fe, NM 87501
Toll Free (844) 255-9210
Phone: (505) 490-4060
Fax: (505) 490-4883

To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit
https://www.nmag.gov/consumer-complaint-instructions.aspx.

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

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

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

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

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

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

Continuation of Coverage: Any Dependent of the Subscriber covered under this Agreement will have the right to continue coverage under this Agreement or to enroll in any other health plan product on the Marketplace at the applicable time upon

- the death of the Subscriber or
- the divorce, annulment or dissolution of marriage or legal separation of the Spouse from the Subscriber.

When such continuation of coverage is made in the name of the Spouse of the Subscriber, such coverage may, at the option of the Spouse include coverage to Dependent children for whom the Spouse has responsibility for care and support. These

rights established by this Agreement for the Subscriber's Dependents are subject to the limitations and conditions set forth in the remainder of this section.

- The right to continue coverage under this Agreement shall not exist with respect to any covered family member of the Subscriber in the event the coverage under this product terminates (a) for cancelation of this Agreement by Subscriber, (b) nonpayment of premium, (c) nonrenewal of this Agreement or (d) the expiration of the term for which this Agreement has been issued. With respect to any covered family member who is eligible for Medicare or any other similar federal or state health insurance program, the right to a continuation of coverage under this section shall be limited as provided by any applicable law. Individuals that qualify for Medicare due to End-Stage Renal Disease (ESRD)/kidney failure disease may be allowed to continue their coverage under this Agreement and continue to receive federal premium tax credit, if deemed eligible by the Marketplace.
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- Coverage continued under this Agreement or under any other product that Molina is offering on the Marketplace at the applicable time will be provided at a reasonable, nondiscriminatory rate, as permitted by applicable law, and will consist of a form of coverage then being offered by Molina. Continued coverages as provided in this "Continuation of Coverage" section will contain renewal provisions that are not less favorable to the new subscriber than those contained in this Agreement.
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- Molina will provide each covered family member under this Agreement who is 18 years of age or older a statement setting forth in summary form the continuation of coverage provisions established by this section.
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- The eligible covered family member exercising the continuation of coverage as established in this section must notify Molina and make payment of the applicable premium within 30 days following the date that coverage under this Agreement terminates as specified in the termination provisions of this Agreement.
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- The rights established in this section can only be exercised to the extent of applicable law. For example, a covered family member under this Agreement or such person's dependent child still must meet the eligibility and enrollment requirements established by the Marketplace or other applicable laws for enrollment in health plan products and receipt of affordable tax credits to reduce the cost of such products may be available under the Affordable Care Act.
-
- Furthermore, since the Affordable Care Act makes various health coverage options available the Member and their Dependents on a guaranteed issue basis, this

section will only apply to the Member's Dependents if Molina is required, at the time, by applicable law to provide such coverage.

Time Limit on Certain Defenses: As of the date of issue of this Agreement, no misstatements, except willful or fraudulent misstatements, made by the Member in the application for this Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability (as defined in the Agreement).

In the event a misstatement in an application is made that is not fraudulent or willful, Molina may prospectively rate and collect from the insured the Premium that would have been charged to the insured at the time the Agreement was issued had such misstatement not been made.

The Rights of Custodial Parents: When a child has health coverage through a noncustodial parent, Molina will provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage; permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for Covered Services without the approval of the noncustodial parent; and make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the health care provider, or the state Medicaid agency.

The Rights of Non-Custodial Parents: Molina acknowledges the rights of the Non-Custodial Parents of children who are covered under a Custodial Parent's health insurance coverage unless these rights have been rescinded per court order or divorce decree. Non-Custodial parents are able to contact Molina, obtain, and provide necessary information, including, but not limited, to health care provider information, claim information and benefit/services information for that child.

Members Eligible for Medicaid: Molina will pay the New Mexico Human Services Department ("HSD") any indemnity benefits payable by Molina on behalf of a Member when:

- HSD has paid or is paying benefits on behalf of the Member under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
- Payment for the services in question has been made by HSD to the Medicaid provider; and
- Molina is notified that the Member receives benefits under the Medicaid program and that the indemnity benefits payable by Molina must be paid directly to HSD (the notice may be accomplished through an attachment to the claim by HSD for the indemnity benefits when the claim is first submitted by HSD to Molina).

Members Eligible for Medicare: Each Member entitled to coverage under Medicare must notify Molina in writing.

Wellness Program: This Agreement includes access to a health activities program. The goal of the program is to encourage Members to complete health activities that support their overall health. The program is voluntary and available at no cost. The health activities Molina encourages Members to complete are described below. For more information, please contact Customer Support.

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

MEMBER GRIEVANCE AND APPEAL PROCEDURE

Molina Healthcare's Grievance and Appeal Procedure is overseen by Our Grievance and Appeal Unit. Its purpose is to resolve issues and concerns from Members. Molina will provide the member a written copy of Our grievance and appeal process upon request. Molina will never retaliate against a Member in any way for filing a grievance or appeal.

Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and complaint forms by Molina at each step. In addition, you can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau** page found under the **Departments** tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from Molina at: www.MolinaMarketplace.com or from OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?
You may request a review of two different types of decisions:

Adverse determination: You may request a review if your insurer has denied pre- authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (Molina must notify you *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by Molina of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative decision: You may also request a review if you object to how Molina handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a health care service work?
When Molina receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

Coverage: First, Molina determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

Medical necessity: Next, if Molina finds that the requested service is covered by the policy, Molina determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that Molina pay for cosmetic plastic surgery to give you a more attractive nose, Molina might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, Molina might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, Molina may deny certification. Your insurer might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. However, you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: Molina must make an initial decision within 5 working days. However, Molinamay extend the review period for a maximum of 10 calendar days if it: **(1)** can demonstrate reasonable cause beyond its control for the delay; **(2)** can demonstrate that the delay will not result in increased medical risk to you; and **(3)** provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from Molina is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** the physician with knowledge of your medical condition **reasonably** requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an urgent care situation **or** Molina has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and Molina must either certify or deny the initial request quickly. Molina must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

If you are dissatisfied with Molina's initial expedited decision in an urgent care situation, you may then request an **expedited review** of Molina's decision by both Molina and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, Molina must review its prior decision and respond to your request within 72 hours. If you request that an IRO perform an expedited review simultaneously with Molina's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records.

If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete. The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency

When will I be notified that my initial request has been either certified or denied?
If the initial request is approved, Molina must notify you and your provider within 1 working day after the decision, unless an urgent matter requires a quicker notice. If Molina denies certification, Molina must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?
If your initial request for services is denied or you are dissatisfied with the way Molina handles an administrative matter, you will receive a detailed written description of the grievance procedures from Molina as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. Molina provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the Molina's member service as follows:

Telephone: 1 (888) 295-7651 or if you are hard of hearing you may contact our TTY at 1 (800) 659-8331
Address: PO Box 3887, Albuquerque, NM 87190
Fax #: 1-(505) 342-0583
E-mail: Marketplace.Grievances@MolinaHealthCare.com

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674 Address: Office of Superintendent of Insurance - MHCB

P.O. Box 1689, 1120 Paseo de Peralta Santa
Fe, NM 87504-1689
FAX #: (505) 827-6341,
Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?
A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review
If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?
You must notify Molina that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?
If you request that Molina review its decision, Molina will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?
Expedited review. If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the service. The medical director's review generally takes only a few days.

The medical director denied my request - now what?
If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by Molina or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your health provider may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may NOT request an IRO review if you skip the panel review.

How long do I have to make my decision?
If you wish to have your request reviewed by the insurer's panel, you must inform Molina within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?
If you request that Molina provide a panel to review its decision, Molina will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because Molina felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

Molina will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that Molina will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement. The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you have already received the services. You will be notified within 1 day after the panel decision. If you fail to provide records or other information that Molina needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months** to request a review by an IRO.

What's an IRO and what does it do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with Molina or with you. The reviewer will consider all of the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then Molina must provide them.

The IRO's fees are billed directly to the insurer – there is no charge to you for this

How long does an IRO review take?
The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance
If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.
The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?
If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within **180 days** after the date you are notified of the decision. Molina will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?
Molina will mail a decision to you within 30 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?
Yes. You have **20 days** to request that Molina form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?
When Molina receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after Molina receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.
If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days.
The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?
If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674.

How does the external review work?
Upon receipt of your request, the Superintendent will request that both you and Molina submit information for consideration. Molina has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and Molina and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

Cost Sharing general information:

- All cost sharing (including copayments, deductibles, co-insurance, or similar charges) required of covered persons by the health care insurer or managed health care plan for the provision of health care services shall be reasonable and shall include any applicable state and federal taxes.
- Any cost sharing requirement for the provision of testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency is presumptively unreasonable and is prohibited. For purpose of this rule, a public health emergency exists when declared by the ~~s~~state of New Mexico or federal government.
- Cost sharing requirements, including any variations in contribution requirements based on the type of health care service rendered or provider used, shall be disclosed to covered persons in MHCP contracts, enrollment materials, and in the evidence of coverage.
- No female covered person shall be assessed a higher cost sharing requirement, over and above the cost sharing required of all covered persons to be seen by a primary care physician, for choosing a women's health care provider as her primary care physician.
- Health care services for any disease or condition for which cost sharing is prohibited under bullet two of this section shall be subject to the Surprise Billing Protection Act, Sections 59A-57A-1 through 13, NMSA 1978 (the "Act"). Where there is no data available in the Act's benchmarking databases for a particular billing code, then Molina shall reimburse under the Act at one hundred fifty percent of the Medicare reimbursement rate applicable for the year in which the benchmarking data first becomes available.

Coverage of sex specific health services and medically necessary services for transgender individuals: For transgender people, preventive services will not be limited based on an individual's sex assigned at birth, gender identity or recorded gender. Additionally, indicate that coverage and claims will not be denied or limited or subject to additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

Molina Healthcare of New Mexico, Inc
Notice of Right to Complain – Maternity Postpartum Care

The Molina Healthcare of New Mexico, Inc. "Molina" Agreement and Individual Evidence of Coverage (EOC) affords you postpartum care benefits as specified in the EOC. The Member's postpartum care benefits are summarized below. Please review the EOC and Summary of Benefits for a complete description of benefits, including Cost-Sharing amounts and other requirements.

MATERNITY POSTPARTUM CARE

Molina covers the following maternity postpartum care services:

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays need to be Authorized by Molina in consultation with the Member's physician. (Inpatient Hospital Services Maternity Cost Sharing will apply.)

- If the Member's doctor, after talking with the Member, decides to discharge the Member and the Member's newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is shortened, then at least 3 home care visits will be provided. The Member and the Member's physician may agree that 1 or 2 visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory Tests Cost Sharing will apply to laboratory services).

If the Member believes that they did not receive your maternity postpartum care benefits, the Member has the right to complain to the New Mexico Superintendent of Insurance. The Superintendent may be contacted at the following address:

New Mexico Office of the Superintendent of Insurance
Attn: Managed Health Care Bureau
PO Box 1689
1120 Paseo de Peralta
Santa Fe, NM 87504-1689
Email: mhcb.grievance@state.nm.us
Toll Free: (855) 427-5674
Fax: (505) 827-4734

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)

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Molina Healthcare of New Mexico, Inc.
Notice to Covered Member – Maternity Postpartum Care

The Molina Healthcare of New Mexico, Inc. "Molina" Agreement and Individual Evidence of Coverage (EOC) affords you postpartum care benefits as specified in the EOC. The Member's postpartum care benefits are summarized below. Please review the EOC and Summary of Benefits for a complete description of benefits, including Cost-Sharing amounts and other requirements.

MATERNITY POSTPARTUM CARE

Molina covers the following maternity postpartum care services:

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays need to be Authorized by Molina in consultation with the Member's physician. (Inpatient Hospital Services Maternity Cost Sharing will apply.)

- If the Member's doctor, after talking with the Member, decides to discharge the Member and the Member's newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is shortened, then at least 3 home care visits will be provided. The Member and the Member's physician may agree that 1 or 2 visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory Tests Cost Sharing will apply to laboratory services).

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.

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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)

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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)

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2021

Molina Healthcare of New Mexico, Inc. Agreement and Individual Evidence of Coverage

Molina Pediatric Vision Services Rider No. 1

New Mexico

PO Box 3887, Albuquerque, NM 87190

MolinaMarketplace.com

MOLINA HEALTHCARE

Your Extended Family.

This Pediatric Vision Services Rider No. 1 amends and supplements the Molina Healthcare of New Mexico, Inc. Agreement and Individual Evidence of Coverage (also called the "**EOC**" or "**Agreement**") and is issued by Molina Healthcare of New Mexico, Inc. ("**Molina Healthcare**", "**Molina**") for the product specified as part of the Agreement.

The following provisions of the Agreement are amended as follows:

1. The Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC) is amended and supplemented by adding the following summary of pediatric vision services to the category of "Outpatient Professional Services" covered under the Agreement:

Outpatient Professional Services (cont'd)	**At Participating Provider, You Pay**
Pediatric Vision Services (for Members under age 19 Only) Services must be provided by a participating VSP provider.	
Vision Exam (limited to 1 routine eye exam each calendar year)	No Charge
Prescription Glasses *Frames* • Limited to 1 pair of frames every calendar year • Limited to a selection of covered frames *Lenses* • Limited to 1 pair every calendar year • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistance coating UV protection	No Charge
Prescription Contact Lenses • In lieu of prescription glasses, prescription contact lenses covered with a minimum three-month supply for any of the following modalities every calendar year: • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) • Medically Necessary contact lenses for specified medical conditions require Prior Authorization.)	No Charge
Low Vision Optical Devices and Services (Subject to limitations and Prior Authorization.)	No Charge

THE GUIDE ABOVE IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF NEW MEXICO, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE, AS AMENDED BY THIS PEDIATRIC VISION SERVICES RIDER NO. 1, SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS."

2. The "Pediatric Vision Services" section under "What is Covered Under My Plan?" is deleted in its entirety and replaced by the following provisions:

"**Pediatric Vision Services**

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

- One routine eye exam in a 12-month period
- One pair of prescription eye glasses (lenses and frame) no more frequently than once every 12 months (prescription eye glasses may be covered more frequently when an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to, cataracts, diabetes or hypertension)
- Lens tinting if certain medical conditions are present as confirmed by ophthalmologist or optometrist
- Polycarbonate lenses if medical conditions require prescriptions for high power lenses or an eligible Member has monocular vision
- Lenses to prevent double vision
- Minor repairs to prescription eye glasses

Contact lenses (original prescriptions or replacements) are covered only when Prior Authorized for certain medical conditions. We cover the replacement of eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that they have become unusable to eligible Members. Laser corrective surgery is not covered."

3. All provisions of the Agreement which are not deleted, modified, supplemented or otherwise amended by this Pediatric Vision Services Rider No. 1 remain in full force and effect.

4. The provisions of the Agreement, together with this Pediatric Vision Services Rider No. 1, any other riders or amendments to the Agreement, and any application(s) submitted to Molina Healthcare to obtain coverage under the Agreement , including the applicable rate sheet for this plan, are incorporated into the Agreement by reference, and constitute the legally binding contract between Molina Healthcare, on the one hand, and Subscriber or Member, on the other.

5. Pediatric Vision Services that are obtained by a non-participating provider are not covered. Should You or Your eligible Dependents who are enrolled in this Policy obtain Pediatric Vision Services with a non-participating provider You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum for any of these services.

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ទ្រមង់ែសម ងអក្សរែប
ទំហំអក្សរធំេយរែតត្រមវរពិេសសរបស់អក
ឬរបស់អកេយមិនគិតតៃមបែនមេឡើយ។ (Cambodian)

YOUR PRIVACY

Your privacy is important to Us. We respect and protect Your privacy. Molina uses and shares Your information to provide You with health benefits. Molina wants to let You know how Your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes your name, Member number, date of birth, address, phone number or other identifiers, and is used or shared by Molina.

Why does Molina use or share Our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run Our health plan
- To use or share PHI for other purposes as required or permitted by law. Examples include for public health and health care oversight purposes.

When does Molina need Your written authorization (approval) to use or share Your PHI?
Molina needs Your written approval to use or share Your PHI for reasons not listed above.

What are Your privacy rights?

- You can look at Your PHI
- You can get a copy of Your PHI
- You can amend Your PHI
- You can ask Us to not use or share Your PHI in certain ways. Examples include restrictions on sharing Your PHI with family members or certain other persons.
  .
- You can get a list of people or places We have given Your PHI

How does Molina protect Your PHI?
Molina uses many ways to protect PHI. This includes written or spoken PHI. It includes PHI in a computer. Here are some ways Molina protects PHI:

- We have policies and rules to protect PHI.
- We limit who may see PHI. Only Molina staff who need to know PHI may use it.
- Our staff is trained on how to protect and secure PHI.
- Our staff must agree in writing to follow the rules and policies that protect and secure PHI
- We secure PHI in Our computers. PHI in Our computers is kept private with firewalls and passwords.

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. Our Notice is in the next section of this EOC and is on Our web site at www.molinahealthcare.com. You can get a copy of Out Notice of Privacy Practices. Call Our Customer Support Center at 1 (888) 295-7651.

NOTICE OF PRIVACY PRACTICES

MOLINA HEALTHCARE OF NEW MEXICO, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT TELLS YOU HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Molina Healthcare of New Mexico, Inc. ("**Molina Healthcare**", "**Molina**", "**we**" or "**Our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment. We use it for payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2014.

PHI stands for these words, protected health information. PHI means health information that includes Your name, Member number, date of birth, address, phone number or other identifiers, and is used or shared by Molina.

Why does Molina use or share Your PHI?
We use or share Your PHI to provide You with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment
Molina may use or share Your PHI to give or arrange for Your medical care. This treatment also includes Referrals between Your doctors or other health care providers. For example, We may share information about Your health condition with a specialist physician. This helps the specialist physician talk about Your treatment with Your doctor.

For Payment
Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, Your condition, Your treatment, and supplies given may be written on the bill. For example, We may let a doctor know that You have Our benefits. We would also tell the doctor the amount of the bill that We would pay.

For Health Care Operations
Molina may use or share Your PHI to run Our health plan. For example, we may use Your claims PHI to tell You about programs that could help You. We may use or share Your PHI to solve a concern. Your PHI may be used to make sure claims are paid.

Health care operations can include:

- Improving quality;
- Actions to help Members with certain conditions (such as asthma);
- Doing or arranging for medical review;
- Legal services;
- Fraud and abuse detection programs;
- Actions to help Us obey laws;
- Address Member needs;
- Solving complaints and grievances.

We will share Your PHI with other companies ("**business associates**") that do different activities for Our health plan. This includes pharmacy benefit managers and records storage companies. We may also use Your PHI to remind You about Your appointments. We may use Your PHI to give You information about other treatment, or other health-related benefits and services.

When can Molina use or share Your PHI without getting written authorization (approval) from You?

The law allows or requires Molina to use and share Your PHI. We may do this for many reasons listed here.

- **Required by Law**
  We will use or share information required by law. We will share Your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, legal review, or law enforcement.

- **Public Health**
  Your PHI may be used or shared for public health. This may include helping public health agencies to prevent or control disease.

- **Health Care Oversight**
  Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

- **Research**
  Your PHI may be used or shared for research.

- **Law Enforcement**
  Your PHI may be shared with police to help find a suspect, witness or missing person.

- **Health and Safety**
  Your PHI may be shared to prevent a serious threat to public health or safety.

- **Government Functions**
  Your PHI may be shared with the government for special functions. An example would be to protect the President.

- **Victims of Abuse, Neglect or Domestic Violence**
  Your PHI may be shared with legal authorities if We believe that a person is a victim of abuse or neglect.

- **Worker's Compensation**
  Your PHI may be used or shared to obey Workers Compensation laws.

- **Other Disclosures**
  Your PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI? Molina needs Your written approval to use or share Your PHI for any reason not listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given Us. Your cancellation will not apply to actions already taken by Us.

What are Your health information rights?
You have the right to:

- **Request Restrictions on Sharing of Your PHI**
  You may ask Us not to share Your PHI to carry out treatment, payment or health care operations. You may also ask Us not to share Your PHI with family or other persons You name who help in Your health care. However, We are not required to agree to Your request.

  You will need to make Your request in writing. You may use Molina's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina to give You Your PHI in a certain way or at a certain place to help keep it private. We will follow reasonable requests. You must tell Us how sharing that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI. This may include records used in making coverage, claims and other decisions as a Molina Member. You will need to make Your request in writing. You may use Molina's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases, We may deny the request. Important Note: We do not have complete copies of Your medical records. If You want to look at, get a copy of, or change Your medical records, please contact Your doctor or clinic.

- **Amend Your PHI**
  You may ask that we amend (change) Your PHI. This involves only those records kept by Us about You as a Member. You will need to make Your request in writing. You may use Molina's form to make Your request. You may file a letter that disagrees with Us if we deny the request.

- **Sharing of Your PHI**
  You may ask that we give You a list of certain parties that we shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:
    - For treatment, payment or health care operations;
    - To persons about their own PHI;
    - Sharing done with Your authorization;
    - Incident to a use or disclosure otherwise permitted or required under applicable law;
    - As part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if You ask for this list more than once in a 12- month period. You will need to make Your request in writing. You may use Molina's form to make Your request.

You may make any of the requests listed above. You can get a paper copy of this Notice. Please call Our Customer Support Center at 1 (888) 295-7651.

What can You do if Your rights have not been protected?
You may complain to Molina and to the U.S. Department of Health and Human Services. You can do this if You believe Your privacy rights have been violated. We will not do anything against You for filing a complaint. Your care and benefits will not change.

You may complain to Us at:

Customer Support Center
PO Box 3887
Albuquerque, NM 87190
1 (888) 295-7651

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

What are the duties of Molina Healthcare?
Molina Healthcare is required to:

- Keep Your PHI private;
- Give You written information such as this on Our duties and privacy practices about PHI;
- Give You notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting;
- Follow the terms of this Notice

This Notice is Subject to Change
Molina reserves the right to change Our information practices and terms of this Notice at any time. If We do, the new terms and practices will then apply to all PHI We keep, subject to changes in law. If We make any material changes, Molina will post the revised Notice on Our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in Our next annual mailing to Our Members then covered by Molina.

Contact Information
If You have any questions, please contact the following office:

Customer Support Center
PO Box 3887
Albuquerque, NM 87190
1 (888) 295-7651
Telecommunications [TTY 7-1-1]

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 می‌کنید، خدمات کمک زبانی، بدون هزینه در دسترس شما هستند. با خدمات اعضا تماس بگیرید. شماره تلفن روی پشت کارت شناسایی 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)

YOUR PRIVACY

Your privacy is important to Us. We respect and protect Your privacy. Molina uses and shares Your information to provide You with health benefits. Molina wants to let You know how Your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes your name, Member number, date of birth, address, phone number or other identifiers, and is used or shared by Molina.

Why does Molina use or share Our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run Our health plan
- To use or share PHI for other purposes as required or permitted by law. Examples include for public health and health care oversight purposes.

When does Molina need Your written authorization (approval) to use or share Your PHI?
Molina needs Your written approval to use or share Your PHI for reasons not listed above.

What are Your privacy rights?

- You can look at Your PHI
- You can get a copy of Your PHI
- You can amend Your PHI
- You can ask Us to not use or share Your PHI in certain ways. Examples include restrictions on sharing Your PHI with family members or certain other persons.
  .
- You can get a list of people or places We have given Your PHI

How does Molina protect Your PHI?
Molina uses many ways to protect PHI. This includes written or spoken PHI. It includes PHI in a computer. Here are some ways Molina protects PHI:

- We have policies and rules to protect PHI.
- We limit who may see PHI. Only Molina staff who need to know PHI may use it.
- Our staff is trained on how to protect and secure PHI.
- Our staff must agree in writing to follow the rules and policies that protect and secure PHI
- We secure PHI in Our computers. PHI in Our computers is kept private with firewalls and passwords.

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. Our Notice is in the next section of this EOC and is on Our web site at www.molinahealthcare.com. You can get a copy of Out Notice of Privacy Practices. Call Our Customer Support Center at 1 (888) 295-7651.

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(Japanese)

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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)