Molina Healthcare of New Mexico, Inc Marketplace

2024
Agreement and Individual Evidence of Coverage Form

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

MOLINA® HEALTHCARE

PEDIATRIC DENTAL NOTICE: THIS AGREEMENT 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/Alaska Natives do not have Cost Sharing when they receive Covered Services from Participating Providers.
- For individual Plans with limited Cost Sharing, American Indians/Alaska Natives do not have Cost Sharing when they receive Covered Services from an Indian Health Care Provider, or from another Provider if they have a referral from an Indian Health Care Provider. For more information, please visit MolinaMarketplace.com.

Interpreter Services: Molina offers interpreter services for any Member who may need language assistance to understand and obtain health coverage under this Agreement. Molina provides these services at no additional cost to the Member. Molina will provide oral interpretation services and written translation services for any materials vital to a Member understanding their health care coverage. Members who are deaf or hard of hearing can use the Telecommunications Relay Service by dialing 711.

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

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 meet once every three (3) months and suggests improvements 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 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.

Accrued interest rate: Accrued interest rate applies when a non-participating provider does not reimburse the Member within 45 days of request in accordance with State law.

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

Getting Care	• 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
		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 • View benefits and Member Handbook • View or Print ID card • Track claims	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaHealthcare.com/ProviderSearch
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card support • Access to care • Prenatal care • Well-child visits	Molina Member Services 1 (888) 295-7651 Monday through Friday, 8:00 a.m. to 6:00 p.m. (Mountain Time) **Go to** MyMolina.com
Billing and Payment Services	• Premium Payment Questions	1 (800) 253-0217 Monday through Friday, 8:00 a.m. to 6:00 p.m. (Mountain Time) **Go to** MolinaPayment.com
New Mexico Health Insurance Exchange	• Eligibility questions • Add a Dependent • Report change of address or income	**Go to** beWellnm.com 1-855-427-5674
New Mexico Managed Health Care Bureau Office of Superintendent of Insurance		**Go to** P.O. Box 1689, Santa Fe, NM 87504-1689 Tel: 1(505) 827-4601 Toll Free: 1(855) 427-5674 www.osi.state.nm.us

TABLE OF CONTENTS

CONTENTS

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, and the applicable Summary of Benefits and Coverage (SBC) for this plan, 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.

Entire Contract; Changes: This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

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

Thank You for Choosing Molina

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 Molina of New Mexico Agreement and Individual Evidence of Coverage ("Agreement") to tell you:

How you can get services through Molina, including:

- Getting an interpreter
- Choosing a Primary Care Provider (PCP)
- Making an appointment

The terms and conditions of coverage under this Agreement
Benefits and coverage as a Molina Member

- Checking on Prior Authorization status

How to contact Molina

Please read this Agreement carefully. Inside is information about a wide range of health needs and services provided. For questions or concerns, please reach out to Customer Support at MolinaMarketplace.com or 1 (888) 295-7651.

We look forward to serving you,

Molina Marketplace

DEFINITIONS

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

Administrative Decision: A decision made by Molina regarding any aspect of a health benefits plan other than an adverse determination, including but not limited to:

administrative practices of the health care insurer that affect the availability, delivery, or quality of health care services;
claims payment, handling or reimbursement for health care services, including but not limited to complaints concerning co-payments, co-insurance and deductibles; and terminations of coverage.

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, a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, or investigational or not medically necessary or appropriate, application of utilization review or Medical Necessity. This can include rescission of coverage. and applicability of State or Federal Surprise Billing protections.

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

Allowed Amount: The maximum portion of a billed charge that Molina will pay, including any applicable covered person Cost Sharing responsibility, for a covered health care service or item rendered by a participating provider or by a nonparticipating provider. 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 "OUT-OF-NETWORK CARE AND BILLS" 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 SBC. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

The 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 "OUT-OF-NETWORK CARE AND BILLS" section of this agreement will apply to your OOPM. Such services include: Emergency health care service rendered by a non-participating 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 on-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 Summary of Benefits and Coverage 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, Molina will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year if they remain enrolled in this Plan. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM

amount, Molina will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family if they remain enrolled in this Plan.

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

Biomarker: A characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarker includes gene mutations, characteristics of genes or protein expression.

Biomarker Testing: A analysis of a member's tissue, blood or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing.

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. When applicable, Coinsurances are listed in the SBC.

Complications of Pregnancy: A condition due to pregnancy, labor or 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: s a cost-sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with Molinar paying the allowed balance; there may be different copayment amounts for different types of services under the same health benefits plan. When applicable, Copayments are listed in the SBC.

Covered Person: This means a policyholder or other person covered by a health benefit plan.

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

Covered Service or Covered Services: Medically Necessary services, including some medical devices, preventive care, equipment, and prescription drugs, that Members are eligible 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. SBC.

Please refer to the Molina Healthcare of New Mexico, Inc. 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. Preventive services covered by this Agreement are included in the Essential Health Benefits, and 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.

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

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 prescription drugs this Molina Plan covers. The Drug Formulary also puts drugs in different cost sharing levels or tiers.

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

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

- 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.

With respect to a pregnant woman who is having contractions, an emergency medical condition means that there is adequate time to affect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or child.

Emergency Care: A health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person.

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

Emergency Services: Services to evaluate, treat or stabilize an Emergency Medical Condition. These services may be provided in a licensed emergency 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 an underlying medical condition for which such procedure, medication, facility or device was prescribed.

Facility: means an entity providing a health care service, including:

- a general, specialized, psychiatric or rehabilitation hospital;
- an ambulatory surgical center;
- a cancer treatment center;
- a birth center;
- an inpatient, outpatient or residential drug and alcohol treatment center;
- a laboratory, diagnostic or other outpatient medical evaluation or testing center;
- a health care provider's office or clinic;
- an urgent care center; or
- any other therapeutic health care setting.

FDA: The United States Food and Drug Administration.

Generally Recognized Standards: A standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

- psychiatry;
- psychology;
- social work;
- clinical counseling;
- addiction medicine and counseling; or
- family and marriage counseling

Health Maintenance Organization: A type of health insurance plan that usually requires members to obtain covered services 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 facility offering inpatient services, nursing and overnight care for three or more individuals on a 24-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

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: The State Based Exchange, beWellnm.

Medical necessity or medically necessary: Health care services determined by a provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

- any applicable generally accepted principles and practices of good medical care;
- practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or

any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

Member: An individual who is eligible and enrolled under this Agreement, and for whom Molina has received the applicable first Premium payment (binder). The term includes a Subscriber and a Dependent, 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 themselves.

Mental Health or Substance Use Disorder Services: Medically Necessary professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or professional talk therapy services, provided in accordance with generally recognized standards of care including placing an insured into a medically necessary level of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act [Chapter 61, Article 9A NMSA 1978].
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 Evidence of Coverage: This document, which has information about coverage under this Plan. It is also called the “Agreement”.

Nationally Recognized Clinical Practice Guidelines: A evidence-based clinical practice guidelines that are:

- developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy; and

- used to establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

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

Organ transplant: Includes parts or the whole of organs, eyes or tissue.

Other Practitioner: A Participating Provider 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 who, under an express contract with Molina or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment directly or indirectly from the carrier, subject to any cost-sharing required by the health benefits plan. Also known as an in-network provider or contracted provider.

Practice of Pharmacy: The evaluation and implementation of a lawful order of a licensed practitioner; the dispensing of prescriptions; the participation in drug and device selection or drug administration that has been ordered by a licensed practitioner, drug regimen reviews and drug or drug-related research; the administering or prescribing of dangerous drug therapy, devices or supplies for prescribed drug therapy for health conditions, including diabetes; the provision of patient counseling and pharmaceutical care; the responsibility for compounding and labeling of drugs and devices; the proper and safe storage of drugs and devices; the ordering, performing and interpreting of tests authorized by the federal food and drug administration and waived pursuant to the federal Clinical Laboratory Improvement Amendments of 1988, as amended; and the maintenance of proper records. A pharmacist may order, test, screen, treat, and provide preventive services for Flu, Strep Throat, SARS, UTIs, HIV for prep only, and an illness subject to an active PHE.

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.

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

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

Prior Authorization or **pre-certification** means a pre-service determination made by Molina regarding a Member's eligibility for health care services based on medical necessity, health benefits coverage and the appropriateness and site of services pursuant to the terms of the health benefits 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, and 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 is a recission of coverage and prohibited by law. 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.

Summary of Benefits and Coverage (SBC): A summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective subscriber or covered person by Molina..

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.

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

State Law: The body of law in 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 non-participating 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 non-participating provider; or
> (b) health care services, that are not emergency care, rendered by a non-participating provider at a participating facility where:
>
> > 1) a participating provider is unavailable;
> > 2) a non-participating provider renders unforeseen services; or
> > 3) a non-participating provider renders services for which the covered person has not given specific consent for that non-participating 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 non-participating provider without Prior Authorization; or
(b) received for health care services rendered by a non-participating 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: Occurs 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.

Surprise Billing Protection Act;

- Cost-sharing and benefits limitations for an emergency health care service rendered by a non-participating 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.

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 of this Plan, an individual must meet all eligibility requirements established by the Marketplace. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber for this Plan.

Open Enrollment Period: The Marketplace will set a yearly period in which eligible individuals can submit an application and enroll in a health 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 changes established by the Marketplace. The Effective Date of a Member's coverage will be determined by the Marketplace. For more information about Open Enrollment and Special Enrollment Periods, please visit: beWellnm.com.

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

Dependents: Subscribers who enroll during the Open Enrollment Period established by the Marketplace may also apply to enroll eligible individuals as Dependents. Dependents

must meet the eligibility requirements, as established by the Marketplace. Dependents are subject to the terms and conditions of this Agreement. Molina does not limit Dependent eligibility based on financial dependency, residency, status as a student, employment, eligibility for other coverage, or marital status. The following individuals are considered Dependents:

- **Spouse**: The individual lawfully married to the Subscriber under State Law.
- **Child or Children**: The Subscriber's son, daughter, adopted child, stepchild, foster child or 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 to be a Dependent if the child meets the following eligibility criteria:

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

- **Domestic Partner**: An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but isn't married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace and State Law.

Adding New Dependents: An individual may become eligible to be a Dependent after the Subscriber becomes enrolled in this 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 in foster care, adoption, placement for adoption, child support, or other court order.
- 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/guardian 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, or
- 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 or enrolled spouse is eligible as a Dependent at birth. A newborn is automatically covered for 31 days, at the moment of birth if notification of birth of a newly born child and payment of the required premium is furnished to beWellnm within thirty-one days after the moment of birth in order to have the coverage from birth. A newborn child is eligible to continue enrollment if they are enrolled within Molina within 60 days.

Spouse: A Spouse may be added as a Dependent of the Subscriber and 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 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 a final decree of divorce, annulment or dissolution of marriage is entered between the Dependent Spouse and Subscriber
- The date a termination of the domestic partnership decree between the Subscriber and Domestic Partner is entered
- For Child-Only Coverage, at 11:59 p.m. (Mountain Time) on the last day of the calendar year in which the non-Dependent Member reaches the limiting age of 21. The Member and any Dependents may be eligible to enroll in other products offered by Molina through the Marketplace
- Date the Subscriber loses coverage under this Plan

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

PREMIUM PAYMENT

To begin and maintain coverage under this Plan, Molina requires Members to make monthly payments in consideration, known as Premium Payments or Premiums. Premium Payments are made to your Marketplace.

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

Late Payment Notice: For questions regarding late payment notices please contact beWellnm at 1 (833) 862-3935.

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 three consecutive months for a Subscriber and their Dependents, who when failing to timely pay Premiums, is receiving APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for services in the second and third months of the Grace Period; Molina will terminate this Agreement as of 11:59 p.m.(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 consecutive days for a Subscriber and their Dependents, who when failing to timely pay Premiums, are not receiving an APTC. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. During the Grace Period, Molina will pay all appropriate claims for services rendered to the Subscriber and their Dependents. Molina will terminate this Agreement as of 11:59 p.m. (Local Time) on the last day of the Grace Period if Molina does not receive all past due Premiums from the Subscriber.

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

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

Re-enrollment After Termination for Non-Payment: For questions please contact beWellnm at 1 (833) 862-3935.

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

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. Please see the Grace Period section of this agreement for additional information. 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.

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not enrolled with Molina. Coverage for a former Member ends at 11:59 p.m. Mountain Time on the day before the termination date. Molina will provide notice of termination to the Member, including the reason for termination, at least 30 days prior to the termination date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date.

Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within 30 days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud or intentional misrepresentation. Molina may terminate or not renew a Member for any of the following reasons:

Dependent and Child-Only Ineligibility Due to Age: A Dependent no longer meets the eligibility requirements for coverage required by the 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 notice 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: For questions please contact beWellnm at 1 (833) 862-3935.

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;
- Treatment received during the second or third trimester of pregnancy through the postpartum period, or a course of treatment received at any stage of pregnancy that is related to a pregnancy;
- Any treatment being received for a terminal illness; 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; or
- 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 the Prior Authorization review process. Members may contact Molina to initiate Prior Authorization review.
- Molina will only provide Covered Services on or after Member's effective date of coverage with Molina, not prior. Previous 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 that crosses coverage dates. 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 before.

Access To Care

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

24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is 1 (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 Member's Deductible or OOPM. However, a Member may receive Covered Services from a Non-Participating Provider for the following:

- Emergency Services
- Post Stabilization Services, unless the Member waives Balance Billing protections
- Services by a Non-Participating Provider at a Participating Facility, unless the Member waives Balance Billing protections
- Air ambulance services
- Services from a Non-Participating Provider that are subject to Prior Authorization (including providers for mental health or substance use disorder services)
- 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
- In the event medically necessary covered services are not reasonably available through a participating provider, Molina and the PCP or other participating provider shall refer a covered person, once prior Authorization is obtained, to a non-participating health care professional and shall fully reimburse the non-participating health care professional at the usual, customary, and reasonable rate or at an agreed upon rate. Before Molina denies a referral to a non-participating provider or health care professional, the request will be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

To locate a Participating Provider, please refer to the provider directory at MolinaMarketplace.com/NMGetCare or call Member Services to request a hard copy. Molina will provide a written bi-annual notice of any deletions or additions to the list of primary care physicians in the member's area, and shall make more recent updated lists available to Members upon request. pursuant to 13.10.23.8D NMAC.

Because Non-Participating Providers are not in Molina's contracted Provider network, unless Balance Billing protections apply, they may Balance Bill Members for the difference between Molina's Allowed Amount and the rate that they charge.

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

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

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 that are under this agreement and the payments for such services will not apply to their Deductible or OOPM. For exceptions, Members should review the Covered Services section of the Agreement and refer to applicable Balance Billing protections through Federal and State Law.

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 Member Services.

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

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

Telehealth Services: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. Covered Services are also available through Telehealth, except as specifically stated in this Agreement. 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 a method of accessing Covered Services, and not a separate benefit

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

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 Member Services to request reasonable accommodation assistance.

Physical Access: Every effort has been made to ensure that Molina's offices and the offices of Participating Providers are accessible to persons with disabilities. Members with special needs should call Molina's Member Services 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 Member Services at the TTY 711 number for assistance.

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

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

PRIOR AUTHORIZATION

Prior Authorization Requirement

Certain types of care require prior authorization by us.

- This means that you or your provider must ask us to approve the care before you receive it.

- A complete and current list of the services and prescription drugs that are subject to a prior authorization requirement can be found at MolinaMarketplace.com/NMGetCare.

Molina Healthcare of New Mexico, Inc. ("Molina") may decline payment for unauthorized care. If your provider is participating, and you did not agree to receive unauthorized care, your provider cannot bill you for the care. If you received unauthorized care from a provider who is not participating you may be fully responsible for the resulting bills.

Molina does not require prior authorization for:

- emergency services;
- contraception services that are not subject to any cost-sharing; or
- an obstetrical or gynecological ultrasound.

However, Molina requires authorization for continued in-patient care if you are admitted to a hospital for emergency treatment, but your condition is stabilized. You or your provider must notify us within 24 hours from when you begin receiving emergency in-patient treatment, and within 24 hours after the emergency ends and your condition stabilizes.

Prior Authorization Process

Your in-network provider is responsible for knowing what care requires prior authorization, and for submitting a prior authorization request to us.

Molina will give any provider access to all necessary forms and instructions for making the request. This includes the acceptance of the uniform prior authorization request form(s) developed by the superintendent and found on the superintendent's website at www.osi.state.nm.us

A out-of-network provider is not required to submit a prior authorization request for you. If you visit one of these providers, and that provider will not submit a prior authorization request, you may submit a prior authorization request on your own behalf, or on behalf of a dependent. Molina will help you obtain required documents and show you the guidelines that apply to the request. However, because your provider should be able to gather

required information and submit it sooner, Molina encourages you to have your provider request prior authorization whenever possible.

Prior Authorization Review Timelines

If Molina does not deny a complete prior authorization request within these time frames the request is automatically approved:

- **Urgent Care or Prescription Drugs –** If you require urgent medical care, behavioral health care or a prescription drug, Molina will resolve the request within 24 hours.
- **Non-Urgent Medicine –** if you do not have an urgent need for a prescription drug, Molina will resolve the request within three business days if your provider:
    - Uses the prior authorization request form approved by the New Mexico Office of Superintendent of Insurance;
    - Requests an exception from an established step therapy process; or
    - Requests to prescribe a drug that Molina does not usually cover.
- **Other Requests –** Molina will resolve all other requests within seven (7) business days.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Molina maintains a record of each prior authorization request and associated documentation, our utilization management staff can answer questions your provider might have concerning required information or any aspect of the request submission process. If Molina requires additional information to evaluate a request, Molina will request it from your provider. Your provider will have at least 4 hours to provide requested information in connection with an urgent prior authorization request, and at least two calendar days for any other type of request.

Why Molina Review

Our review of a prior authorization request will determine if the proposed care involves a covered service, is medically necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medical necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional.

Prior authorization does not guarantee payment. Molina is not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

If you received care without a required prior authorization, Molina may allow your provider to request authorization retrospectively. Our utilization management team will assist your provider in the submission of a retrospective authorization request. However, Molina does not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request prior authorization.

Behavioral Health Care

Requests for behavioral health care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions. In accordance with SB273 Molina cannot retroactively change a PA for behavioral health services after rendered, except in cases of fraud. Also Molina cannot require PA for acute behavioral health care, acute episodes of chronic behavioral health conditions, or initial substance use treatment. Molina cannot stop coverage without consulting with the treating behavioral health provider. No PA for substance use medications. No step therapy for medically necessary substance use treatment medications.

Authorization Denial

Molina will inform you in writing if Molina denies a prior or retroactive authorization request. Our notice to you will explain why Molina denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process begins on page 1 of this document. You have a right to request information about the guidance Molina followed to deny your request, even if you do not dispute our decision

Prior Authorization List

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) , non-mental health/substance use related)
- Surgery
- Medical equipment and supplies
- Advanced Imaging and Specialty Tests
- Electroconvulsive Therapy (ECT); and
- Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- Cosmetic, Plastic and Reconstructive Procedures: No PA required with Breast Cancer Diagnoses.

- Durable Medical Equipment
- Elective Inpatient Admissions
    - Acute Hospital
    - Skilled Nursing Facilities (SNF)
    - Acute Inpatient
    - Long Term Acute Care (LTAC) Facilities
- Experimental/Investigational Procedures
- Genetic Counseling and Testing
- Healthcare Administered Drugs (this includes sites of service such as outpatient hospital, SNF, infusion center, physician's office)
- Home Healthcare Services (including home-based PT/OT/ST)
- Hyperbaric/Wound Therapy
- Neuropsychological and Psychological Testing will require review after initial treatment
- Non-Participating Providers/Facilities as described in the Access to Care section
- Occupational, Physical & Speech Therapy
- Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures
- Pain Management Procedures
- Orthotics
- Radiation Therapy and Radiosurgery
- Sleep Studies: Except Home (POS 12) sleep studies
- Transplants/Gene Therapy, including Solid Organ and Bone Marrow
- NEMT Transportation
- Vision as described in the Vision Services (Adult and Pediatric) section

Concurrent Review List

Some services require notification and a process called Concurrent Review. If a service requires Concurrent Review 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 require Concurrent Review. For inpatient acute care, Molina will coordinate services within 48 hours and will continue to follow up every 48 hours.

- Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services will require notification and concurrent review after initiation of in-network mental health or substance use disorder treatment.
    - Inpatient, Transitional Substance Abuse Residential;

- Treatment, Day Treatment, Partial Hospitalization;
- Electroconvulsive Therapy (ECT); and
- Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).

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

Prescription Drugs and Medications: Prior Authorization decisions and notifications for access to medications not listed on the Molina Formulary will be provided as described in the section of this Agreement titled "Prior Authorization", "Access to Non-Formulary Drugs" or "Requesting an Exception". Prior Authorizations use uniform Prior Authorization forms for prescription drug Prior Authorization protocols as required by State Law.

Medical Necessity: Prior Authorization and concurrent review determinations are made based on a review of Medical Necessity for the requested service. Molina is here to help Members throughout this process. If a Member has questions about how a certain service may be approved, visit MolinaMarketplace.com or contact Member Services. Molina can explain how that type of decision is made. The number is 1 (888) 295-7651. TTY users may dial 711.

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

Molina will not approve a Prior Authorization if information requested in connection with reviewing the Prior Authorization is not provided. If a service request is not Medically Necessary, it will not be approved. If the service requested is not a Covered Service, it will not be approved. Members will get written notification informing them why the Prior Authorization request was not approved. The Member, the Member's authorized representative or their Provider may appeal the decision. The denial decision letter will inform Members how to appeal.

These instructions are also in the section of this Agreement titled Member Grievance and Appeal Procedure. Members may obtain the clinical review criteria used to determine Medical Necessity for authorization requests by contacting Member Services.

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

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

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

Second Opinion: A Member'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- 855-427-5674, or visit The New Mexico Office of Superintendent of Insurance website at www.osi.state.nm.us .

OUT-OF-NETWORK CARE AND BILLS

If you receive care under any of the circumstances below from a provider who is not in your network, these are your rights:

If you receive emergency care out-of-network, including air ambulance service:

- You are only responsible for paying what you would owe for the same care from an in-network provider or facility.
- You do NOT need to get prior authorization for emergency services.
- Your care can continue until your condition has stabilized. If you require additional care after stabilization, call us at 1 (888) 295-7651 and Molina Healthcare of New Mexico, Inc ("Molina"). will help you receive that care from an in-network provider.
- You cannot be balance billed.

If you receive care from an out-of-network provider at an in-network facility, such as a hospital that is in your plan, you are only responsible for paying what you would owe for the same care from an in- network provider if:

- you did not consent to services from an out-of-network provider,
- were not offered the service from an in-network provider, or
- the service was not available from an in-network provider – as determined by your health care provider and your health insurance company.

If you get a bill from an out-of-network provider under any of the above circumstances that you do not believe is owed:

- Call us first at 1 (888) 295-7651. Molina will try to the resolve the issue with the provider on your behalf.
- Contact the New Mexico Office of Superintendent of Insurance if the problem has not been resolved by us – www.osi.state.nm.us or 1- 855-427-5674.

To help stop improper out-of-network bills, Molina will:

- Notify you if your provider leaves our network and allow you transitional care with that provider at the in-network benefit level for up to 90 days depending on your condition and course of treatment.
- Verify the accuracy of our provider directory information at least every 90 days.
- Confirm whether a provider is in-network if you contact us at 1 (888) 295-7651. If our representative provides inaccurate information that you rely on in choosing a provider, you will only be responsible for paying your in-network cost sharing amount for care received from that provider.

You have the right to receive notice of the following before you receive out-of-network care at an in- network facility:

- A good faith estimate of the charges for out-of-network care.
- At least five days to change your mind before you receive a scheduled out-of-network service. If you choose to receive out of network care you will be responsible for out-of-network charges that Molina does not cover.
- A list of participating providers and the option to be referred to any such provider who can provide necessary care.

If you pay an out-of-network provider more than Molina determines you owe:

- The provider will owe you a refund within 45 days of receipt of payment by us.

- If you do not receive a refund within that 45-day period, the provider will owe you the refund plus interest.
- You may contact the New Mexico Office of Superintendent of Insurance at www.osi.state.nm.us and 1-855-427-5674 for assistance or to appeal the provider's failure to provide a refund. You need to file the appeal within 180 days of the 45-day refund period expiration.

COST SHARING

Molina requires Members to pay Cost Sharing for certain Covered Services under this Agreement. Members should review their SBC 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. Cost sharing for covered prescription drugs is due at the time the network pharmacy dispenses the Member's prescription. Formulary tiering and plan design cost sharing are described in the "Prescription Drugs" section of this Agreement and Schedule of Benefits for your plan.

COVERED SERVICES

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

- The individual receiving Covered Services on the date the Covered Services are rendered is a Member;
- The Covered Services are Medically Necessary and/or approved by Molina;
- The services are identified as Covered Services in this Agreement or under state and federal statutes; and
- 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 corresponding federal regulations. Services that are not EHBs will be specifically described in this Agreement.

EHB coverage includes at least the 10 categories of benefits identified in the ACA and its corresponding federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. (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 corresponding federal regulations governing EHBs:

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

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

Acupuncture/Acupressure Services: Molina covers acupuncture services when furnished by licensed Participating Providers that is determined to be Medically Necessary and appropriate for the treatment of the Member's conditions. Acupuncture is a treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the member's provider. It is recommended that acupuncture be part of a coordinated plan of care approved by the member's provider. The acupuncture/acupressure benefit is limited to 20 visits per plan year unless the service is prescribed by a provider for Habilitative or Rehabilitative purposes.

Approved Clinical Trials: Molina only 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 to participate in an approved clinical trial, an enrolled Member must be diagnosed with cancer or other life-threatening disease or condition and be accepted into an Approved Clinical Trial (as defined below). 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 specific drug. 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, drug, 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 routine Covered Services while in 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 performed during a clinical trial. Members should contact Member Services for further information.

Autism Spectrum Disorder (ASD): Molina covers 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.

- Diagnosis of autism; and
- Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

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.

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 which includes home school.

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. See Mental Health Services (Inpatient and Outpatient) for additional information.

Bariatric Surgery (limited to one per lifetime): Molina covers hospital 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, and all of the following requirements must be met to receive these services:

- Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related co- morbid medical conditions;
- Complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes. These changes are necessary for long-term bariatric surgery success; and
- 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.

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. SBC.

Molina will cover dietary evaluations and counseling for the medical management of morbid obesity and obesity. Prescription drugs medically necessary for the treatment of obesity and morbid obesity are also covered.

Biomarker Services: Molina covers biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of a member’s disease or condition when the test is supported by medical and scientific evidence, including:

- labeled indications for a United States food and drug administration-approved or -cleared test;
- indicated tests for a United States food and drug administration-approved drug;
- warnings and precautions on United States food and drug administration labels;
- federal centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or
- nationally recognized clinical practice guidelines.

Molina ensures coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples; and a member and their provider who prescribes biomarker testing have clear, accessible and convenient processes to request an appeal of a benefit denial by Molina please refer to the Member Grievance and Appeal Procedure section in this agreement for more details on appeals. Imaging cost share applies.

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

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections (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 (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more information)
- Skin cancer behavioral counseling (age 6 months to 24 years)

Chiropractic Services: Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments, services are offered at PCP cost share. Chiropractic services are subject to the following:

- The practitioner/provider determines in advance that chiropractic treatment can be expected to result in significant improvement in the member's condition within a period of two months.
- Chiropractic treatment is specifically limited to treatment by means of manual manipulation, i.e., by use of hands and other methods of treatment approved by the plan, including, but not limited to, ultrasound therapy.
- Subluxation must be documented by chiropractic examination and documented in the chiropractic record. Molina will not require radiologic (X-ray) demonstration of subluxation of chiropractic treatment.
- Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

Limited to 20 visits per calendar year unless associated to Habilitative and Rehabilitative services.

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

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. 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 covers all medically necessary benefits and services outlined in this Agreement, which includes medically necessary tracheal shave for gender affirming care and the treatment of gender dysphoria.

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

- Accidental injury to sound natural teeth, jawbones or surrounding tissue. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury and will not be covered.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, outpatient and/or anesthesia for non-covered dental services, are covered, if provided in a hospital or ambulatory surgical center for dental surgery. For members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
- For members for whom local anesthesia is ineffective of acute infection, anatomic variation or allergy.
- For covered dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
- For members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be inefficient or compromised.
- For other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.
- Oral surgery that is medically necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.

- Pediatric dental services, including routine check-ups, major dental care, and orthodontia. See attached documents.
- Removal of infected teeth in preparation for an organ transplant, joint replacement surgery or radiation therapy of the head and neck.

Refer to Temporo/Craniomandibular Joint Disorders (TMJ/CMJ) section for Temporo/Craniomandibular Joint Disorders (TMJ/CMJ) benefits *Molina does not provide pediatric dental services under this Agreement.*

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

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

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

- Screening for gestational diabetes
- Dietician services
- Nutritional counseling

In accordance with state law for Diabetes Care a member who has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner.

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 Member satisfies all medical necessity 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 devices used to correct a body function including clubfoot deformity.

In accordance with state law for Diabetes Care a member who has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner.

Limitations on orthotic appliances: Foot orthotics or shoe appliances are only cover the most appropriate prosthetic or custom orthotic device determined to be medically necessary by the member's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for the comfort or convenience of the member, which includes 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.

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 body's growth necessitates replacement.

Examples of prosthetic devices include, but are not limited to:

- breast prostheses when required because of mastectomy and prophylactic mastectomy
- prosthetics related to other medically necessary services related to gender affirming care and the treatment for gender dysphoria
- 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 change 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 owns the wheelchair that is being repaired.

Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics: Molina provides coverage for initial and secondary prosthetic devices and custom orthotics in a non-discriminatory manner, and without restriction based on predetermined utilization limits, at the same level and cost-sharing as the coverage provided for medical and surgical benefits. Prosthetic and custom orthotic devices are considered habilitative and rehabilitative essential health benefits and are not subject to separate financial requirements or utilization restrictions. Coverage includes:

- Clinical care
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming, strength training.
- All services, including design, fabrication, and repair
- Replacement, without regard to reasonable useful lifetime restrictions, including replacement necessary due to a change in the patient's condition or the condition of the device if replacement the device requires repairs costing more than 60 percent of replacement cost.
- Access to prosthetic and custom orthotic devices from at least two distinct device providers in-network.

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Prosthetic and custom orthotic benefits will not be denied for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity. However, coverage for prosthetic devices and custom orthotics will not be provided when required solely for comfort or convenience.

Surgical Dressing: Surgical dressings that require a practitioner's/provider's prescription, and cannot be purchased over the counter are covered when medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

Gradient compression stockings are covered for:

- Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation
- Venous stasis ulcers that have been treated by a practitioner/provider or other health care professional requiring medically necessary debridement (wound cleaning).
  Lymphedema wraps and garments prescribed under the direction of a lymphedema therapist are covered.

Eyeglasses and contact lenses (Limited) will only be covered under the following circumstances:

- Contact lenses are covered for the correction of aphakia (those with no lens in the eye), keratoconus, or conditions related to IEM. This includes the eye refraction examination.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if medically necessary) is covered within 12 months after cataract surgery or when related to genetic inborn error of metabolism. This includes eye refraction examination, lenses and standard frames.

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

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

Emergency Services Rendered by a Non-Participating Provider: Molina covers Emergency Services obtained from Non-Participating Providers in accordance with State and Federal Law. Emergency Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Summary of Benefits and Coverage at the in-network level. Members are not subject to Balance Billing for Emergency Services.

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

Post-Stabilization Services Rendered by a Non-Participating Provider: Except as set forth below when transfer to a Participating Provider Hospital is appropriate, or when any other benefit exclusions apply, Molina covers Post-Stabilization Services obtained from

Non-Participating Providers in accordance with State and Federal law. Covered Post-Stabilization Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Summary of Benefits and Coverage at the in-network level.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services, Post-Stabilization Services, and other exceptions identified in this Agreement. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility. If the Member refuses the transfer, additional services provided in the Non-Participating Provider facility, including Post-Stabilization Services, are not Covered Services. Non-Covered Services may not be entitled to Balance Billing protections and the provider may balance bill Members for these services. The Member will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of-Pocket.

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

Emergency ambulance: A ground or air ambulance services delivered to a member who requires emergency health care services under circumstances that would lead a reasonable/prudent layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. Emergency ambulance services are covered only under the following circumstances:

- Within New Mexico, to the nearest in-network facility where emergency health care services and treatment can be rendered, or to an out-of-network facility if an in-network facility is not reasonably accessible or able to provide required care. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside of New Mexico, to the nearest appropriate facility where emergency health care services and treatment can be rendered. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Molina will not pay more for air ambulance services than it would have paid for ground ambulance services over the same distance unless a member's condition renders the utilization of such ground transportation services medically inappropriate.
- In determining whether a member acted in good faith as a reasonable/prudent layperson when obtaining emergency ambulance services, Molina will take the following factors into consideration:

- Whether the member required emergency health care services,
- the presenting symptoms
- Whether a reasonable/prudent layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health.
- Whether the member was advised to seek an ambulance service by the member's practitioner/provider or Molina's customer service. Any such advice will result in reimbursement for all medically necessary services rendered, unless otherwise limited or excluded under this plan.

- Ground or air ambulance services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols High Risk Ambulance Services are defined as ambulance services that are:

  - Non-emergency
  - Medically necessary for transporting a high-risk patient
  - Prescribed by your practitioner/provider

- Coverage for High-Risk Ambulance Services is limited to:

  - Air ambulance service when medically necessary. However, Molina will not pay more for air ambulance service than it would have paid for transportation over the same distance by ground ambulance services, unless your condition renders the utilization of such ground ambulance services medically inappropriate.
  - Neonatal ambulance services, including ground or air ambulance service to the nearest tertiary care facility when necessary to protect the life of a newborn or mother.
  - Ground or air ambulance services to any Level I or II or other appropriately designated trauma/burn center according to treatment protocols.

- Inter-facility transfer ambulance services are defined as ground or air ambulance service between hospitals, skilled nursing facilities or diagnostic facilities. Inter-facility transfer services are covered only if they are:

  - Medically necessary

- Prescribed by your practitioner/provider
- Provided by a licensed ambulance service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

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:

Contraception Coverage: You are entitled to receive certain covered contraception services and supplies without cost sharing and without prior approval from us. This means that you do not have to make a co-payment, coinsurance, satisfy a deductible or pay out-of-pocket for any part of contraception benefits listed in this summary if you receive them from an in-network provider.

You may be required to pay a copay, coinsurance, and/or a deductible if you receive a contraception service or supply from an out-of-network provider if the same service or supply is available in-network. You may also owe cost sharing if you receive a brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

Covered Contraceptive Methods: Your plan covers these contraceptive methods:

- Sterilization Surgery for Women (including Tubal ligation)
- Sterilization Surgery for Men
- IUD Copper
- IUD with Progestin
- Implantable Rod
- Shot/Injection
- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)

- Patch
- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide
- Emergency Contraceptive – “Plan B”
- Emergency Contraceptive – “Ella”

Long-Acting Reversible Contraceptives: The Long Acting Reversible Contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without cost-sharing by your plan are listed here: MolinaMarketplace.com/NMFormulary2024. Coverage with no cost-sharing also applies to IUD insertion and removal, including surgical removal, and to any related medical examination when services are obtained from an in-network provider. Coverage of LARCs with no cost-sharing also includes (pre-discharge) post- partum clinical services.

Oral Contraceptives: The oral contraceptives covered by your plan are listed here: MolinaMarketplace.com/NMFormulary2024.

Six Month Dispensing: You are entitled to receive a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. To receive this benefit, your provider must specifically prescribe the six-month supply. If you need to change your contraceptive method before the six- month supply runs out, you may do so without cost-sharing. You will not owe cost sharing for any related contraceptive counseling or side-effects management.

Brand Name Drugs or Devices: Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Please see the table of contraceptive categories above. Ask your provider about a possible equivalent.

If your provider determines that a brand-name contraceptive is medically necessary, your provider may ask us to cover that contraceptive without cost-sharing. If we deny the request, you or your provider can submit a grievance to contest that denial.

Vasectomies and Male Condoms: This plan covers vasectomies and male condoms. No prescription or cost sharing is required for coverage of male condoms. Please see the section below on Coverage for Contraception Where a Prescription Is Not Required for instructions on reimbursement for condoms.

Sexually Transmitted Infections: Sexually transmitted infection means chlamydia, syphilis, gonorrhea, HIV and relevant types of hepatitis, as well as any other sexually

transmitted infection regardless of mode of transportation, as designated by rule upon making a finding that the particular sexually transmitted infection is contagious. Your plan covers, and no cost sharing applies to, contraception methods that are prescribed for the prevention of sexually transmitted infections. This includes screening, testing, examination or counseling and the administration, dispensing or prescribing of preventive measures or medications incidental to the prevention of a sexually transmitted infection. Also, medically necessary care as determined by a health care provider for the management of an existing sexually transmitted infection.

Coverage for Contraception Where a Prescription Is Not Required: Your plan covers contraception with no cost sharing even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a prescription when obtained through an in-network pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within 90 days of the date of purchase of the contraceptive method,
- Provide the receipt with the reimbursement form available at https://www.molinamarketplace.com/marketplace/nm/en-us/-/media/Molina/PublicWebsite/PDF/members/common/en-us/Marketplace/Rx-Reimbursement-Form.pdf, to the following:

  CVS Caremark
  P.O. Box 52136
  Phoenix, AZ 85072-2136

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within 30 days of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within 45 days. Failure to submit a complete request may lead to delays in reimbursement.

Availability of Out-of-Network Coverage: Under your plan, use of an out-of-network provider to prescribe or dispense contraceptive coverage is not a covered benefit.

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: Molina covers hearing aids and certain related services, coverage includes one hearing aid prescribed by a participating provider every 36 months of coverage under this EOC. Services can be accessed by a non-participating provider if prior authorized by Molina. The Member will pay the Cost-Share indicated on the SBC under Durable Medical Equipment.

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. These services include medically necessary skilled intermitted health care services provided by a registered nurse or a licensed practical nurse; physical occupational, and/or respiratory therapist and/or speech pathologist. Intermittent Home Health aide services are only covered when part of an approved plan of care which includes skilled services. These services may include:

- Collection of specimens to be submitted to an approved laboratory facility for analysis.
- Medical equipment, prescription drugs and medications, laboratory services and supplies deemed medically necessary by a practitioner/provider for the provision of health services in the home, except durable medical equipment, will be covered.
- Home health care or home intravenous services as an alternative to hospitalization, as determined by the practitioner/provider.
- Total parenteral and enteral nutrition as the sole source of nutrition.
- 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 6 months or less). Services must be provided by an approved hospice program during a hospice benefit period and will not be covered to the extent that they duplicate other covered services available to you. Benefits that are approved by a hospice provider or other facility require approval by your practitioner/provider. 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.

The hospice benefit period is defined as follows:

- Beginning on the date your practitioner/provider certifies that you are terminally ill with a life expectancy of six months or less.

- Ending six months after it began, unless you require an extension of the hospice benefit period below, or upon your death.
- If a member requires an extension of the hospice benefit period, the hospice must provide a new treatment plan and the practitioner/provider must re-authorize the member's medical condition to the plan. The plan may not authorize more than one additional hospice benefit period.
- The individual seeking hospice care must be a covered member throughout his or her hospice benefit period.

Services: The following services are covered:

- Inpatient hospice care
- Practitioner/provider visits by certified hospice practitioner/providers
- Home health care services by approved home health care personnel
- Physical therapy
- Medical supplies
- Prescription drugs and medication for the pain and discomfort specifically related to the terminal illness
- Medical transportation
- Respite care (care that provides a relief for the care-giver) for a period not to exceed five continuous days for every 60 days of hospice care. No more than two respite care stays will be available during a hospice benefit period.
- Where there is not a certified hospice program available, regular home health care services benefits will apply.

Hyperbaric Oxygen: Hyperbaric oxygen therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS) or as medically necessary.

Hypnotherapy (Limited) – Hypnotherapy is only covered when performed by an anesthesiologist or psychiatrics, trained in the use of hypnosis when medically necessary or when:

- Used within two weeks prior to surgery for chronic pain management and
- For chronic pain management when part of a coordinated treatment plan

Inpatient Hospital Services: Members must have a Prior Authorization before receiving covered hospital services, except in the case of Emergency Services and Post-Stabilization Services, and initial Mental Health/Substance Use Disorder Services. Post-Stabilization Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services, will be covered provided the Member's coverage with Molina has not terminated and the Member has not waived Balance Billing protections pursuant to Federal Law. 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
For exceptions, Members should review the Access to Care section of the Agreement.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Inpatient hospital services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the member's primary care provider or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary. 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. Prior Authorization may be required. for covered scanning services can include CT Scans, PET Scans, MRI. and). Mammograms are covered for symptomatic or high risk women at any time upon referral of the member's health care provider. One baseline mammogram covered for individuals age thirty-five through thirty-nine, which includes Digital breast tomosynthesis (3D mammography) See the preventive coverage section in this Agreement for preventive coverage. Molina can assist Members select an appropriate facility for these services. Limited coverage for Medically Necessary dental and orthodontic X-rays is outlined in the Dental and Orthodontic Services section of this Agreement. Cost share applies.

Mental Health Services (Inpatient and Outpatient): In agreement with state law, Molina covers a continuum of Mental Health Services when provided by Participating Providers and facilities acting within the scope of their license. Molina covers the diagnosis or treatment of mental disorders, including services for the treatment of gender-identity or gender dysphoria.

Cost sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders. This includes cost sharing for inpatient facility services, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient facility services, and all medications, including brand-name pharmacy

drugs when generics are unavailable. Cost sharing means any copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

Molina may require authorization for coverage of services, including inpatient and certain outpatient services. The concurrent review authorization process applies to all involuntary admissions. See the “Inpatient Concurrent Review” section of this Agreement for more information. Except in cases in which the member terminates a plan, Molina will not terminate coverage of services without consultation with the member's mental health or substance use disorder services provider.

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

Molina does not cover career, marriage, parental or job counseling or therapy. In addition, treatment or testing within an inpatient setting related to Pervasive Developmental Disorders, including autism spectrum disorder, learning disabilities, and/or cognitive disabilities are not covered, unless otherwise stated in this agreement. Molina does not cover services for mental health conditions that the DSM identifies as something other than a Mental Disorder.

Molina generally covers the following Medically Necessary Mental Health Services:

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

Mental Health Parity and Addiction Equity Act: Molina complies with the federal Mental Health Parity and Addiction Equity Act. Molina ensures that the financial requirements and treatment limitations on Mental Health Services or Substance Use Disorder benefits provided are no more restrictive than those on medical or surgical benefits.

Observation services: Observation services are defined as outpatient services furnished by a hospital and provider on the hospital’s premises. These services may include the use

of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to:

- Evaluate an outpatient's condition
- Determine the need for a possible admission to the hospital
- When rapid improvement of the member's condition is anticipated or occurs

When a hospital places a member under outpatient observation, it is based upon the provider's written order. To transition from observation to inpatient admission, level of care criteria may need to be met. The length of time spent in the hospital is not the sole factor Molina will use to determine an observation versus inpatient stay. Molina will also consider medical criteria.

Phenylketonuria (PKU) And Other Inborn Errors Of Metabolism: Testing and treatment of phenylketonuria (PKU) and other inborn errors of metabolism that involve amino acids, carbohydrates or fat metabolism 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 at Participating Providers and facilities including, but not limited to:

- Artery calcification testing
- Computerized Axial Tomography (CAT) scans
- Office visits, including:
    - Associated medical supplies
    - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician's office, an outpatient facility, or an inpatient setting. (Including coverage for the use of chemical agents or radiation to treat or control a serious illness)

    - Diagnostic procedures including:

        - Bone density studies
        - Clinical laboratory tests and related professional services

- Colonoscopies (colonoscopies include removal of polyps during the procedure that is at no cost sharing to the member)
- Cardiovascular testing and neurology/neuromuscular procedures
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiation therapy (Members may be subject to facility and professional Cost Sharing based on the place of service)
- 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. Dependents have direct access to obstetrical and gynecological care
    - Sleep studies, sleep studies are covered outpatient and in home. 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 except as required to reverse prior voluntary sterilization surgery. (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 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)

- 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 Case Manager about the Member's health problems. The Case Manager can help the Member learn about those problems and how to manage them. The Case Manager may also work with the Member's family or caregiver to make sure the Member gets the care they need and 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 Member Services 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 covers the following maternity care services:

- Prenatal care
- Outpatient maternity care including Medically Necessary supplies for a home birth
- Childbirth in a hospital or licensing birthing center
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia
- Miscarriage
- Laboratory services that are medically necessary
- 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. This care includes Neonatal care for the newborn.
- 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.
- Pregnancy related diagnostic tests, including 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.

- Minimum of 3 home visits, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests as required by state law.
- Nutritional supplements for prenatal care when prescribed by a practitioner/provider
- are covered for pregnant women.
- Nutritional counseling as medically necessary
- Nutritional supplements that require a prescription to be dispensed are covered when prescribed by a practitioner/provider and when medically necessary to replace a specific documented deficiency.
- Nutritional supplements administered by injection at the practitioner's/provider's office are covered when medically necessary.
- Enteral formulas or products, as nutritional support, are covered only when prescribed by a practitioner/provider and administered by enteral tube feedings.
- Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is covered when ordered by a practitioner/provider.
- Special medical foods as listed as covered benefits in the Genetic Inborn Errors of Metabolism(IEM) benefit or as medically necessary.

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.

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

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

Preventive Services: In accordance with the Affordable Care Act and as part of the 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:

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations. 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
- Preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- HRSA Women's Preventive Services Guidelines.
- Preventive care services as required by State law or requirement, which includes but not limited to:
  - Artery Calcification – a heart artery calcium scan.
  - limited to the provision of a heart artery calcium scan to be used as a clinical management tool;
  - provided every five years if a member has previously received a heart artery calcium score of zero; and
  - not be required for future heart artery calcium scans if a member receives a heart artery calcium score greater than zero.
  - screening, testing, examining, counseling, or administering/dispensing anything to prevent STIs, or medically necessary treatment of STIs
  - Mammograms as follows:
    - For the purpose of symptomatic or high risk women at any time upon referral of the woman's health care provider
    - a mammogram biennially to persons age forty through forty-nine,
    - one mammogram annually to persons age 50 and older, and
    - Coverage shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography and in accordance with state law

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. As new recommendations and guidelines for preventive services are published and recommended by the government 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
- Custom fabricated knee-ankle foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for members in accordance with nationally recognized guidelines.
- Braces and other external devises used to correct a body function including clubfoot deformity
- 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. Foot orthotics or shoe appliances are not covered, except for our members with diabetic neuropathy or other significant neuropathy. However, braces that stabilize an injured body part and braces to treat curvature of the spine are covered. One-month rental of a wheelchair is covered if the member owned the wheelchair that is being repaired.

Orthotic appliances may be limited to a calendar year maximum.

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), medically necessary reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedema. Mastectomy benefits may have an annual deductible that applies and may require that the member pays some out of pocket costs.
- Medically necessary services related to gender affirming care and the treatment for gender dysphoria

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. Medically necessary surgeries are not included.

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 offered at PCP cost share.

Short-term rehabilitation services and physical therapy is provided in those instances where the member's primary care provider or other appropriate treating health care professional determines that such services and therapy can be expected to result in the significant improvement of a member's physical condition within a period of two months.

Such services may be extended beyond the two month period upon recommendation by the primary care provider in consultation with Molina prior authorization.

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

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

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 determining 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 Members are always given access to at least one of the tobacco cessation products without prior authorization and are consistent with all State Laws and Requirements and Federal Laws.

- Diagnostic services: Diagnostic services necessary to identify tobacco use, use-related conditions and dependence.
- Pharmacotherapy: Two 90-day courses of pharmacotherapy per calendar year.
- Cessation counseling: A choice of cessation counseling of up to 90 minutes total provider contact time or two multi-session group programs per calendar year.

- initiation of any course of pharmacotherapy or cessation counseling shall constitute an entire course of pharmacotherapy or cessation counseling even if an individual discontinues or fails to complete the course.

    - Molina covers the following at no cost share (please refer to your formulary for additional information)

        - Nicotine gum
        - Nicotine patch
        - Nicotine lozenge
        - Nicotine oral or nasal spray
        - Nicotine inhaler
        - Bupropion
        - Vareniline

Substance Use Disorder (Inpatient and Outpatient): In agreement with state law, Molina covers Medically Necessary inpatient and outpatient treatment for substance use disorder. Inpatient coverage, in a Participating Provider hospital, is only covered for

medical management of withdrawal symptoms. Molina may require authorization for coverage of services, including inpatient and certain outpatient services. Molina covers the following outpatient care for treatment of substance use disorder:

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

Molina does not cover services for alcoholism, 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.

Cost sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders. This includes cost sharing for inpatient facility services, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient facility services, and all medications, including brand-name pharmacy drugs when generics are unavailable. Cost sharing means any copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

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:

- Major endoscopic procedures
- Operative and cutting procedures
- Preoperative and postoperative care
- Anesthesia and the administration of anesthesia. Anesthesia may include coverage of hypnotherapy. General anesthesia may be provided for the following:

- Member exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia cannot be excepted;
- Member for whom local anesthesia is ineffective;
- Children or adolescents who are uncooperative or fearful or uncooperative with dental needs;

- Member's with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective;
- Other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center are medically necessary.

    - Antineoplastic 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

  Surgical dressings that require a provider's prescription and cannot be purchased over the counter are covered when medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

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

  Temporo/Craniomandibular Joint Syndrome (TMJ/CMJ) Services: Molina covers services to treat TMJ/CMJ joint syndrome if all the following conditions apply:

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

- Not Covered: The following services are not covered:

    - Routine, preventive, and major adult dental care.
    - Dental care and dental X-rays are not covered, excepted as specifically provided above.
    - Dental implants.
    - Malocclusion treatment, if part of routine dental care and orthodontics.

- Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are not covered unless the disorder is trauma related.

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 Member Services.

The following transplants are covered:

- 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
  - Asplastic anemia
  - Lymphoma
  - Severe combined immunodeficiency disease (SCID)
  - Wiskott Aldrich syndrome

- Ewing's Sarcoma
- Germ cell tumor
- Neuroblastoma
- Wilm's Tumor
- Myelodysplatic 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.

Molina does not discriminate against anatomical gift recipients which includes a member with a physical or mental disability. Molina's coverage is in accordance with the Jonathan Spradling Revised Uniform Anatomical Gift Act

Limited travel benefits are available for the transplant recipient, live donor (if applicable) and/or 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 (if applicable) 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.

Molina does not cover:

- Non-human organ transplants, except for porcine (pig) heart valve
- Transportation costs for deceased members
- The medical and hospital services of an organ transplant donor when the receipt of an organ transplant is not a member or when the transplant procedure is not a covered benefit
- Travel and lodging expenses except as noted above.

Urgent Care Services: Urgent Care Services are subject to the Cost Sharing in the Summary of Benefits and Coverage. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition due to illness or injury. Urgent conditions are not life-threatening, but require prompt medical attention to prevent serious deterioration in your health. 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. Members can also call Molina customer service. 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 (Pediatric): Molina covers, for all Members, diabetic eye examinations (dilated retinal examinations) once every calendar year. Molina also covers services for medical and surgical treatment of injuries and/or diseases affecting the eye.

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

- Comprehensive vision exam limited to one every calendar year
- Glasses which are limited to one pair every calendar year

- 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

    - Contact lenses which are limited to one pair of standard contact lenses every calendar year instead of glasses
        - 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
    - 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

PRESCRIPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Molina covers drugs ordered by Providers, approved by Molina, and filled through pharmacies in Molina's networks. Covered drugs include over-the-counter (OTC) and prescription drugs as listed on the Formulary. Molina also covers medical drugs ordered or given in a participating facility when provided in connection with a Covered Service. Prior Authorization may be required to have certain drugs covered where indicated on the formulary. 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 networks. 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. To find network pharmacies, please visit MolinaMarketplace.com. A hardcopy is also available upon request made to Member Services.

Molina Formulary: Molina establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the "Formulary". The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on MolinaMarketplace.com/NMFormulary . A hardcopy is also available upon request. The list of products on the Formulary are chosen by a group of medical professionals from inside and outside of Molina. This group reviews the Formulary regularly and makes changes every 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 with 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. These drugs may cost Members more than similar drugs that are on the Formulary if covered on "exception," as described in the next section. Members may ask for non-formulary drugs to be covered. Requests for coverage of non-formulary drugs will be considered for a medically accepted use when Formulary options cannot be used, and other coverage requirements are met. In general, drugs listed on the Formulary are drugs Providers prescribe for Members to get from a pharmacy and give to themselves. Most injectable drugs that require help from a Provider to use are covered under the medical benefit instead of the pharmacy benefit. Providers have instructions from Molina on how to get advanced approval for drugs they buy and treat Members with. Some injectable drugs can be approved to get from a pharmacy using the Plan pharmacy benefit.

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

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

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

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

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

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 or their representative, and the 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, their representative, or Prescriber can appeal Molina's decision. The Prescriber may request to talk to Molina reviewers about the denial.

If an internal appeal of the original coverage determination is requested, Molina will notify the Member, their representative, and the Prescriber, of the internal appeal 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.

The Member or their representative, or the Prescriber may also request that an Independent Review Organization (IRO) review Molina's internal appeal decision. The Member or their representative, and the Prescriber, will be notified 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 Summary of Benefits and Coverage shows Member Cost Share for a one-month supply based on these tiers.

Molina will not require a Member to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

- applicable cost-sharing amount for the prescription drug;
- amount a Member would pay for the prescription drug if the Member purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;
- total amount the pharmacy will be reimbursed for the prescription drug from Molina, including the cost-sharing amount paid by Molina; or
- value of the rebate from the manufacturer provided to Molina or its pharmacy benefits manager for the prescribed drug.

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

Drug Tier	Description
Preventive	PREV – Preventative and family planning drugs and devices (ie, contraception) with $0 cost sharing.
Preferred Generic	Tier 1 – Preferred generic drugs.
Preferred Brand and Non-Preferred Generic	Tier 2 – Preferred brand name drugs and some generic drugs that are non-preferred.
Preferred Specialty	Tier 3 – All preferred specialty drugs (brand name and generic); Drugs that require special handling, complex counseling or monitoring, limited distribution, or other special pharmacy requirements; Depending on state rules, Molina may require Members to use a network specialty pharmacy; Some Specialty Drugs are only sold by certain pharmacies the drug company has chosen (“Limited Distribution”).
Non-Preferred Brand	Tier 4 – Non-preferred brand name drugs..
Non – Preferred Specialty	Tier 5 – All non-preferred specialty drugs (brand name and generic); Drugs that require special handling, complex counseling or monitoring, limited distribution, or other special pharmacy requirements; Higher cost sharing than preferred specialty drugs used to treat the same conditions, if available; Depending on state rules, Molina may require Members to use a network specialty pharmacy; Some specialty drugs are only sold by certain pharmacies the drug company has chosen (“Limited Distribution”).

DME	DME – Non-drug items such as monitoring equipment and supplies covered under the pharmacy benefit; Cost sharing follows the medical benefit cost sharing for Durable Medical Equipment for non-drug items on the drug list.

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

Site of Care for Provider-administered Drugs Required Program: For Provider-administered drugs that require Prior Authorization, when coverage criteria are met for the medication, a site of care policy is used to determine the medical necessity of the requested site of care. Site of care means the physical location of injection or infusion administration of a drug for a specialized condition. Molina covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be medically necessary. To review the site of care policy, please visit MolinaMarketplace.com.

Molina will conduct peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina will offer the ordering Provider help in identifying an in-network infusion center, physician office, or home infusion service, and will help the Member coordinate and transition through case management.

Drug Cost Sharing Assistance and Out-of-Pocket Costs: Cost sharing reduction for any prescription drugs obtained by Members through the use of a discount card, a coupon provided by a prescription drug manufacturer, or any form of prescription drug third party cost sharing assistance will apply toward any Deductible, or the Annual Out-of-Pocket Maximum under the Plan in accordance with state law. Molina will apply to the Member the full value of any discounts provided or payments made by the third parties including but not limited to drug company support programs at the time of the prescription drug claim.

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

Durable Medical Equipment (DME): Molina will cover DME rental or purchase costs, including for use with certain drugs, when obtained through a contracted vendor. Molina will also cover reasonable repairs, maintenance, delivery, and related supplies for DME. Members may be responsible for necessary DME repair or replacement costs if needed

due to misuse or loss of the DME. Prior Authorization is required for DME to be covered. In accordance with state law for Diabetes Care a member who has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered person's health care practitioner.

Coverage may be under the medical benefit or the pharmacy benefit, depending on the type of DME. Please refer to the Formulary for DME and other non-drug products covered under the pharmacy benefit. Please refer to MolinaMarketplace.com, or contact Member Services for more coverage information.

Diabetic Supplies: Molina covers diabetic supplies on the Formulary such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, 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, with no Cost Share. Members should consult their Provider to determine which drug is right for them. Covered drugs are listed on the Formulary.

Prescription eye drops: Molina covers medically necessary prescription eye drops as identified on the formulary and as prescribed as the Members provider. The following must be met for a renewal of a prescription:

- the renewal is requested by the Member at least twenty-three days for a thirty-day supply of eye drops, forty-five days for a sixty-day supply of eye drops or sixty-eight days for a ninety-day supply of eye drops from the later of the date that the original prescription was dispensed to the Member or the date that the last renewal of the prescription was dispensed to the Member; and
- the participating provider indicates on the original prescription that additional quantities are needed and that the renewal requested by the insured does not exceed the number of additional quantities needed.

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

Proration and Synchronization: Molina provides medication proration for a partial supply of a prescription drug if the Member's pharmacy notifies Molina that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs, synchronization is in the best interest of the Member, the Member 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 are required for pharmacy coverage of opioid pain medications to treat chronic pain. Without a Prior Authorization, opioid claims have safety limits, including: short supply per fill, and subject to restrictions on long-acting opioid drugs and combined total daily doses. These requirements do not apply to Members in the following circumstances: Opioid analgesics are prescribed to a Member who is a hospice patient, the Member was diagnosed with a terminal condition, or the Member is actively being treated for cancer. Molina will conduct a utilization review for all opioid Prior Authorization requests.

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs (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 SBC for applicable Cost Sharing. Most new anti-cancer drugs are considered the Specialty Drugs under the pharmacy benefit. Coverage for a prescribed, orally administered anticancer medication is not subject to any prior authorization, dollar limit, copayment, deductible or coinsurance provision that does not apply to intravenously administered or injected anticancer medication used to kill or slow the growth of cancerous cells Certain anti-cancer drugs are covered under a partial fill program. Network pharmacies may dispense newly started anti-cancer drugs half a month's supply at a time for the first several fills until Members are stable on the drug and dose.

Mail Order Availability of Formulary Drugs: Molina offers Members a mail order option for certain drugs in the Preventive Drugs, Preferred Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand and Generic Drugs Tiers. Eligible drugs are marked "MAIL" on the Formulary. Formulary drugs will be mailed to a Member within 10 days of order request and approval. Through this option, Members can get a 3-month supply of eligible drugs at reduced Cost Sharing. Cost Sharing for a 3-month supply through mail order is applied at a rate of two and a half times the one-month supply Cost Share at the drug's Formulary tier. Brand and Generic Specialty Drugs Tier drugs are not eligible for 90-day supply programs like Mail Order, though most Specialty medications will be shipped to the Member directly. Refer to the MolinaMarketplace.com or contact Member Services for more information.

Off-Label Drugs: Molina will not deny coverage of off-label drug use solely on the basis that the drug will be used outside of the FDA-approved labeling. Molina does cover off-label drug use to treat a covered, chronic, disabling, or life-threatening illness. The drug must be approved by the FDA for at least one indication. The use must be recognized as standard and effective for treatment of the indication in any of the standard drug reference compendia or substantially accepted peer-reviewed medical literature. Molina may require that other treatments that are also standard have been tried or are not clinically appropriate if permitted under 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
- Experimental and Investigational drugs
- Weight loss drugs, or diabetic drugs when used off-label to lose weight instead of treating diabetes

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

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

EXCLUSIONS

Certain equipment and services are excluded from coverage under this Agreement. These exclusions apply regardless of whether the services are within the scope of a Provider's license, except where expressly stated otherwise in this Section, or where otherwise required by State Law. Please contact Molina Member Services for questions regarding exclusions.

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

General Exclusions: Even if a service, supply, device, or drug is listed as otherwise covered in Details, it is not eligible for benefits if any of the following general exclusions apply.

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 generally covered. 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.

Digital Health and Digital Therapeutics: Mobile applications, software, or hardware devices marketed as digital therapeutics to prevent, manage, or treat medical disorders or behavioral conditions are not covered. This does not apply to formulary continuous glucose monitors or covered insulin pump devices, which are considered durable medical equipment, and are subject to Prior Authorization.

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, Cell Therapy, and Cell-based Gene Therapy: Most gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Molina covers limited gene therapy, cell therapy, and cell-based 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: Molina does not cover infertility services and supplies, including insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

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

Long Term Services and Support (LTSS): not a covered benefit.

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
- Personal convenience items

Massage Therapy: Massage therapy is not covered, unless provided by a licensed physical therapist and as part of prescribed short-term rehabilitation physical therapy program.

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. Medically necessary surgeries are not included.

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

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

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

Services Not Approved by the FDA: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA are not covered. This exclusion

applies to services provided anywhere, even outside the U.S. This exclusion does not apply to services covered under Approved Clinical Trials section. Please refer to the Appeals and Grievances section for information about denied requests for Experimental or Investigational services.

Services Provided Outside the Service Area: Except as otherwise provided in this Agreement, 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. 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 as otherwise covered by this Agreement.

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

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

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

Travel and Lodging Expenses: Travel and lodging expenses are not covered, unless related to Transplant services. Please see the Transplant Services section in this Agreement for more details. Molina may pay certain expenses that Molina Prior Authorizes in accordance with Molina's travel and lodging guidelines.

Vision Care Services: Molina does not cover the following unless specifically stated in the agreement:

- 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

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 (manual claim) and 30 calendar days (electronic claim) after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements.

Notice of Claim: Written notice of claim must be given to the insurance company within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurance company at PO Box 3887, Albuquerque, NM 87190, or to any authorized agent of the insurance company, with information sufficient to identify the insured, shall be deemed notice to the insurance company.

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.

Member Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was pre-approved or does not require pre-approval, Molina will repay the Member. The Member must submit the claim for reimbursement within 12 months from the date they made the payment.

For covered medical services, Members must mail this information to Molina Member Services at the address on the 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 of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid within 30 calendar days and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Written proof of loss must be furnished to Molina at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which Molina is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

For covered prescription drugs, Members must complete a Reimbursement Form found in the Forms section of MolinaMarketplace.com. Members must include a copy of the prescription label and pharmacy receipt when submitting the request form to the address as instructed on the form. After the Member's request for reimbursement is received, it will be processed as a claim under their coverage. The Member will receive a response within 30 calendar days. If the claim is accepted, a reimbursement check will be mailed to the Member. If the claim is denied, the Member will receive 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 SBC 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 Authorization 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.

Acceptance of certain third party payments: Molina accepts premium and Cost Sharing payments from the following third-party entities for 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 such beneficiary or to such estate.. 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 is entitled under any applicable workers' compensation law. The Member is responsible for all action necessary to obtain payment under workers' compensation laws where payment under the workers compensation system can be reasonably expected. Failure to take proper and timely action will preclude Molina's responsibility to furnish benefits to the extent that payment could have been reasonably expected under Workers' Compensation laws. If a dispute arises between the Member and the Workers' Compensation carrier as to a Member's ability to collect under workers' compensation laws, Molina will provide the benefits described in this Agreement until resolution of the dispute. If Molina provides benefits which duplicate the benefits the Member is entitled to under Workers' Compensation law, Molina will be entitled to reimbursement for the reasonable cost of such benefits.

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, accepting enrollment from the Marketplace, or providing medical care on the basis of:

- health status;
- medical condition, including both physical and mental illnesses;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability, including conditions arising out of acts of domestic violence;
- disability (pursuant to federal and state law);
- court order or administrative agency request;
- when a service is available through a public benefit program;
- gender;
- national origin;
- sexual orientation; or
- any other health status-related factor that the superintendent specifies in rules of the office of superintendent of insurance
- gender identity or transgender status.

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
P.O. Box 1689
Santa Fe, NM 87504-1689
Tel: 1-505-827-4601
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 1 (844) 255-9210
Phone: 1 (505) 490-4060
Fax: 1 (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 at 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 of 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 will be allowed to continue their coverage under this Agreement and continue to receive federal premium tax credit, if deemed eligible by the Marketplace.
- 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.
- 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.
- 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.
- 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 to 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).

- No individual or health policy or certificate delivered, issued for delivery or renewed in New Mexico on or after the effective date of this agreement shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the Medicaid program of this state.

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

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

Members should consult with their PCP before participation. The wellness program is optional, and the benefits are made available at no additional cost to eligible members. Rewards and program benefits are available for redemption only while the Subscriber or eligible Dependent is currently enrolled with a Molina marketplace health plan. For more information, please contact Member Services.

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: MolinaMarketplace.com or from OSI by calling 1- 505-827-4601 or toll free at 1- 855-427-5674.

Prior Authorization

How does preauthorization or prior authorization for a health care service work?
When your insurer receives a request to pre-authorize 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, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for equine therapy, then your insurer will not agree to pay for you or your child to have it even if you have a clear need for it.

Medical necessity: Next, if the insurer finds that the requested service is covered by the policy, the insurer 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 your insurer pay for cosmetic plastic surgery to give you a more attractive nose, your insurer may approve your first request for hand surgery but disapprove the second request due to lack of medical necessity.

Experimental or Investigational Services: Depending on terms of your policy, your insurer might also deny authorization 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, the insurer may deny authorization. Your insurer might also deny authorization 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 prior authorization review take?

Standard timeline prior authorization decision: The insurer must make a prior authorization decision for most benefits within 7 working days. A standard decision timeline applies to benefit certification requests that are not urgent. For example, a standard benefit certification request may involve surgical care, like routine hip replacement surgery. An insurer must make an initial decision on a standard request for an exception to an insurer's step-therapy requirements or drug formulary within 24 hours for urgent care requests and 72 hours for standard care request. A step-therapy requirement means trying a less expensive drug before "stepping up" to a more expensive option. Asking for an exception to this requirement means asking to skip the less expensive drug. A drug formulary exception request means to ask for coverage of a medication not on the formulary.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** occurs when a decision from the insurer 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 or behavioral health condition, believes that delay would subject you to severe pain or harm that cannot be adequately managed without the requested care or treatment; or **(5)** the medical or behavioral health demands of your case require an expedited decision.

If you are facing an urgent care situation **or** your insurer 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 the insurer must either authorize or deny the initial request quickly. The insurer 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.

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 has passed. An insurance company is not allowed to require you to obtain prior authorization for emergency care.

When will I be notified that my initial request has been either certified or denied?
The insurance company is required to notify you on its decision about your initial request within the initial certification period timelines listed above. If the insurance company denies your certification request, it is required to tell you about your right to an appeal.

Appeals of Denials

What types of decisions can be appealed?

You may request appeals of two different types of decisions:

Adverse determination: An adverse determination by an insurer includes any decision to deny or limit your coverage based on medical necessity. This medical necessity denial can happen pre-service, through a denial of a prior authorization, or post-service, when an insurance company refuses to pay a claim. If an insurance company has adversely determined that your ongoing course of treatment that has been previously covered will no longer be covered, the insurer must notify you *before* ending or limiting that coverage. 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.

An adverse denial may also include a decision by the plan to retroactively end your coverage or stop offering you coverage in the future based on your eligibility for coverage. For example, an insurance company's decision to stop offering you coverage because they believe you moved out of state is an adverse determination. ***You may request an appeal of any type of an adverse determination.***

Administrative decision: You may also request an appeal if you object to how the insurer 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.

How to Appeal a Decision or File a Grievance

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 your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer 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. The insurer 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 insurer's consumer assistance office as follows:

Telephone: 1 (888) 295-7651 or if you are hard hearing you may contact our TTY at 1 (800) 659-8331
Address: P.O. Box 182273, Chattanooga, TN 37422

Always contact your insurance company first about filing an appeal or grievance and specifically ask for assistance filing an appeal or grievance.

If the insurance company is non-responsive or if you have further questions about your rights, you may contact the New Mexico Office of the Superintendent of Insurance Managed Health Care Bureau consumer assistance team at:

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674

Address: Office of Superintendent of Insurance – MHCB
PO Box 1689 Santa Fe, NM 87504-1689 or
1120 Paseo de Peralta, Fourth Floor, Santa Fe, NM 87501
FAX #: (505) 827-4253, Attn: MHCB
E-mail: mhcb.grievance@osi.nm.gov

Review of an Adverse Determination

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 policy holder or a dependent who receives coverage through the policy holder. The person whose medical benefit is denied is called the **"grievant."** If you are selecting someone to act on your behalf, such as a provider, you may need to fill out a form designating that person to be your representative in the appeal.

Appealing an adverse medical necessity or coverage 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 decide 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 the insurer 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 the insurer review its decision, you can ask the insurer to provide you with a list of the documents you need to provide and will provide to you all 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 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 the insurer 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),

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

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.

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 the insurer 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 the insurer provide a panel to review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer 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.

The insurer 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 the information that the insurer 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 24 hours after the panel decision or sooner if medically necessary. If you fail to provide records or other information that the insurer 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 from the date of the panel decision** to request a review by an IRO.

What's an IRO and what does it do?

An IRO (Independent Review Organization) 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 the insurer or with you. The reviewer will consider all the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO.) In deciding, 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 the insurer must provide them.

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

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 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 **within 20 days of the IRO decision**, 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 pay those fees.

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. The insurer 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?

The insurer 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 the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer 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 the insurer 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 the insurer submit information for consideration. The insurer 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 the information received from both you and the insurer and issue a final decision within 45 days after receipt of the complete request for external review. 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. Call the consumer assistance number on the back of your insurance card for assistance.

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, vaccination 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.

Covered person has the right at a minimum to:

- To available and accessible services when medically necessary, 24 hours per day, seven days per week for urgent or emergency care services, and for other health care services as defined by the Agreement;
- To be treated with courtesy and consideration, and with respect for the covered person's dignity and need for privacy;
- To be provided with information concerning the health care insurers policies and procedures regarding products, services, providers, appeals procedures and other information about the MHCP and the benefits provided;
- To choose a primary care practitioner within the limits of the covered benefits, plan network, and as provided by this rule, including the right to refuse care of specific health care professionals;
- To receive from the covered person's physician(s) or provider, in terms that the covered person understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurers or Molina's position on treatment options; if the covered person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the covered person's medical record;
- To all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the covered person understands;
- To prompt notification, as required in this rule, of termination or changes in benefits, services or provider network;
- To file a complaint or appeal with the health care insurer or the superintendent and to receive an answer to those complaints in accordance with existing law;
- To privacy of medical and financial records maintained by the health care insurer and its health care providers, in accordance with existing law;
- To know upon request of any financial arrangements or provisions between the health care insurer and its providers which may restrict referral or treatment options or limit the services offered to covered persons;
- To adequate access to qualified health professionals for the treatment of covered benefits near where the covered person lives or works within the service area;
- To the extent available and applicable to Molina, to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating provider, and an explanation of a covered person's financial responsibility when services are provided by a non-participating provider, or provided without required preauthorization;
- If Molina provides benefits for out-of-network coverage, the right to an approved example of the financial responsibility incurred by a covered person when going

out-of-network; inclusion of the entire billing examples provided by the superintendent available on the division's website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the division's billing examples requires written approval by the superintendent;

- To detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that a covered person must follow for prior authorization and utilization review;
- To a complete explanation of why care is denied, an opportunity to appeal the decision to the health care insurers internal review, the right to a secondary appeal, and the right to request the superintendent’s assistance.

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 https://www.hhs.gov/ocr/complaints/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.

ATTENTION: Aids and services for people with disabilities, like documents in braille and large print, are also available. If you need help in your language call Member Services located on back of your ID card. (TTY: 711). These services are free of charge.

ATENCIÓN: Si necesita ayuda en su idioma llame a Servicios para Miembros. El número está en el reverso de su tarjeta de identificación de miembro. (TTY: 711). También hay disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y letra grande. Estos servicios son gratuitos. (Spanish)

. تنبيه: إذا كنت بحاجة الى مساعدة في لغتك ، فاتصل، بخدمات الأعضاء. الرقم موجود على ظهر بطاقة هوية العضو الخاصة بك |
(Arabic) .(الهاتف النصي: 711). تتوفر أيضا مساعدات وخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل والطباعة الكبيرة. هذه الخدمات مجانية

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք Member Services: Համարը գտնվում է Ձեր Member ID քարտիետևի մասում: (TTY: 711):
Առկա են նաեւ հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ եւ ծառայություններ, ինչպես բրեյլի եւ մեծ տպաքանակի փաստաթղթեր: Այս ծառայությունները անվճար են: (Armenian)

ការយកចិត្តទុកដាក់ជំនួយនឹងសេវាកម្មសម្រាប់ជនពិការដូចជាឯកសារភ្ជាប់អក្សរធំជាដើមមានផងដែរ.
ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការហៅទាសារបស់អ្នកថាសមាជិកសេវាកម្មដែលមានទីតាំងនៅខាងក្រោយអត្តសញ្ញាណប័ណ្ណរបស់អ្នក, (TTY: ៧១១), សេវាកម្មទាំងនេះដោយមិនគិតថ្លៃ, (Cambodian)

注意:如果您需要语言方面的帮助, 请致电会员服务部。该号码位于您的会员 ID 卡背面。(TTY: 711)。
还为残疾人提供辅助工具和服务, 如盲文和大字体文件。这些服务是免费的。(Chinese Simplified)

توجه: کمک ها و خدمات برای افراد معلول, مانند اسناد بریل
. و چاپ بزرگ نیز در دسترس هستند. در صورت نیاز به کمک در زبان خود با خدمات عضو واقع در پشت کارت شناسایی خود تماس بگیرید
(TTY: 711) . این خدمات رایگان هستند. (Farsi)

ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता है, तो सदस्य सेवाओं को कॉल करें। नंबर आपके सदस्य आईडी कार्ड के पीछे है। (TTY: 711)
। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज, भी उपलब्ध हैं। ये सेवाएं नि: शुल्क हैं। (Hindi)

XIM: Yog koj xav tau kev pab los ntawm koj cov kev pab. Tus naj npawb nyob sab nraum qab ntawm koj tus ID card. (TTY: 711).
Aids thiab kev pab rau cov neeg uas muaj mob xiam oob qhab, xws li cov ntaub ntawv nyob rau hauv braille thiab loj print, kuj muaj. Cov kev pab no yog pab dawb xwb. (Hmong)

ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, rufen Sie den Mitgliederservice an. Die Nummer finden Sie auf der Rückseite Ihres Mitgliedsausweises. (TTY: 711).
Hilfsmittel und Dienstleistungen für Menschen mit Behinderungen, wie Dokumente in Blindenschrift und Großdruck, sind ebenfalls verfügbar. Diese Dienstleistungen sind kostenlos. (German)

注意:あなたの言語で助けが必要な場合は、メンバーサービスに電話してください。番号は会員証の裏面に記載されています。(TTY: 711)。
点字や大活字の書類など、障害者のための援助やサービスも利用できます。これらのサービスは無料です。(Japanese)

주의: 귀하의 언어로 도움이 필요하면 회원 서비스에 전화하십시오. 이 번호는 가입자 ID 카드 뒷면에 있습니다. (TTY: 711) 입니다.
점자 및 큰 활자로 된 문서와 같은 장애인을 위한 보조 및 서비스도 제공됩니다. 이러한 서비스는 무료입니다. (Korean)

ຂໍ້ຄວນລະວັງ: Aids ແລະການບໍລິການສໍາລັບຄົນພິການ, ເຊັ່ນດຽວກັບເອກະສານໃນ braille ແລະການພິມຂະຫນາດໃຫຍ່, ຍັງມີ. ຖ້າ ທ່ານ ຕ້ອງ ການ ຄວາມ ຊ່ວຍ ເຫຼືອ ໃນ ພາ ສາ ຂອງ ທ່ານ call Member Services ທີ່ ຕັ້ງ ຢູ່ ທາງ ຫລັງ ຂອງ ບັດ ID ຂອງ ທ່ານ. (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ. (Loatian)

attention: aids caux services bun mienh caux disabilities oix documents yie braille caux large print naaic yaac available da'faanh meih oix zuqc tengx yie meih nyei language heuc member services located zieqc back of meih nyei yie cie (tty: 711) these services naaic free of charge. (Mien)

BAA'ÁKOHWIINIDZIN: Diné t'áá haash{í yit'éego bich'į' aníhoot'i'ígíí bá áka'anídaalwo'í dóó bee áka'anída'awo'í, díí naaltsoos bee éédahoziní bik'ih nizhdilniihgo wólta'í dóó nitsaago bee bik'eda'ashchínígíí ałdó' hóló. T'áá nizaadjí bee shiká'adoowoł nínízingo ninaaltsoos ID nitł'isí bine'dęę' biká'ígíí bee Bił Hada'dít'éhí Bika'anída'wo' bich'į' hodíilnih. (TTY: 711). Díí bee áka'anída'awo'í doo bą́ą́h ilíní da. (Navajo)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ ਮੈਂਬਰ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਹੈ। (TTY: 711).
ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। (Punjabi)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Navajo, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese

ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните в службу поддержки. Номер указан на обратной стороне вашей идентификационной карты. (Телетайп: 711).
Также доступны вспомогательные средства и услуги для людей с ограниченными возможностями, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Эти услуги бесплатны. (Russian)

ATTENTION: Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Kung kailangan mo ng tulong sa iyong wika tumawag sa Member Services na matatagpuan sa likod ng iyong ID card. (TTY: 711).
Ang mga serbisyong ito ay libre. (Tagalog)

ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโทรติดต่อฝ่ายบริการสมาชิก หมายเลขจะอยู่ด้านหลังบัตรประจำตัวสมาชิกของคุณ (TTY: 711) นอกจากนี้ยังมีบริการช่วยเหลือสำหรับคนพิการ เช่น เอกสารอักษรเบรลล์และสิ่งพิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่าย (Thai)

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711). Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711). Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Navajo, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese