2020

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

Molina Marketplace
New Mexico
PO Box 3887, Albuquerque, NM 87190

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

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKA NATIVE ENROLLED ON A LIMITED COST SHARE PLAN YOU WILL HAVE NO COST SHARING IF YOU OBTAIN COVERED SERVICES FROM ANY PARTICIPATING TRIBAL HEALTH PROVIDER. HOWEVER, YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PLAN FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER. PREVENTIVE SERVICES PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER, OR ANY PARTICIPTING PROVIDER, ARE ALWAYS COVERED AT NO CHARGE TO THE MEMBER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION. IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKA NATIVE ENROLLED ON A ZERO COST SHARE PLAN ALL COVERED SERVICES ARE AT NO CHARGE TO THE MEMBER.

MolinaMarketplace.com

MOLINA HEALTHCARE

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، المجانًا، لك. تتصل بقسم خدمات الأعضاء. يوجد رقم الهاتف هذا على الجزء الخلفي من بطاقة هويتك. (Arabic)

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

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

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

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

توجه؛ اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، بدون هزینه در دسترس شما هستند. با خدمات اعضا تماس بگیرید. شماره تلفن روی پشت کارت شناسایی عضویت شما درج شده است. (Farsi)

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

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

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

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

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេង ដូចជា ទម្រង់ជាសម្លេង អក្សរស្ទាប ទំហំអក្សរធំដោយសារតែតម្រូវការជាពិសេសរបស់អ្នក ឬជាភាសារបស់អ្នកដោយមិនគិតតម្លៃបន្ថែមឡើយ។ (Cambodian)

Subscriber may cancel and return this Agreement and Individual Evidence of Coverage to Molina Healthcare of New Mexico, Inc. within 10 calendar days after delivery and receive a premium refund. If Covered Services are received by any Member during this 10-day examination period, then the Subscriber must pay the full cost of those Covered Services if his or her premium has been returned.

This Molina Healthcare of New Mexico, Inc. Agreement and Individual Evidence of Coverage (also called the "EOC" or "Agreement") is issued by Molina Healthcare of New Mexico, Inc. ("Molina Healthcare", "Molina", "We", or "Our"), 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 described in this Agreement.

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

WELCOME

Welcome to Molina Healthcare!

Here at Molina, We will help You meet Your medical needs. If You are a Molina Member, this EOC tells You what services You can get.

Molina Healthcare is a New Mexico licensed Health Maintenance Organization.

We can help You understand this Agreement. If You have any questions about anything in this Agreement, call Us. You can call if You want to know more about Molina. You can get this information in another language, large print, Braille, or audio. You may call or write to Us at:

Molina Healthcare of New Mexico, Inc.
Customer Support Center
PO Box 3887
Albuquerque, NM 87190
1(888) 295-7651
molinahealthcare.com
If You are deaf or hard of hearing You may contact Us through Our dedicated TTY line. Call toll-free, at 1 (800) 659-8331. You may also dial by 711 for the Telecommunications Service.

INTRODUCTION

Thank You for choosing Molina Healthcare as Your health plan.

This document is called Your "Molina Healthcare of New Mexico, Inc. Agreement and Individual Evidence of Coverage" (Your "Agreement" or "EOC"). The EOC tells You how You can get services through Molina. It also sets out the terms and conditions of coverage under this Agreement. . It tells You Your rights and responsibilities as a Molina Member. It explains how to contact Molina. Please read this EOC completely and carefully. Keep it in a safe place where You can get to it quickly. There are sections for special health care needs.

Molina is here to serve You.

Call Molina if You have questions or concerns. Our helpful and friendly staff will be happy to help You. We can help You:

- Arrange for an interpreter
- Check on a Prior Authorization Status
- Choose a Primary Care Provider
- Make an appointment
- Make a Payment

We can also listen and respond to any of Your questions or complaints about Your Molina product.

Call Us toll-free at 1 (888) 295-7651 between 8:00 a.m. to 5:00 p.m. MT. We are here Monday through Friday. If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line toll-free at 1 (800) 659-8331. You can also dial 711 for the Telecommunications Service.

If You move from the address You had when You enrolled with Molina or if You change phone numbers, contact the Marketplace at 1 (800) 318-2596.

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

1. Cost Sharing and benefits limitations for an Emergency health care service rendered by a nonparticipating provider shall be the same as if rendered by a participating provider. Prior Authorization shall not be required for Emergency health care services.
2. 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.
3. 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.

DEFINITIONS

Some of the words used in this EOC do not have their usual meaning. Health plans use these words in a special way. When We use a word with a special meaning in only one section of this EOC, We explain what it means in that section. Words with special meaning used in any section of this EOC are explained in this "Definitions" section.

"**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

"**Allowed Amount**" means the amount that Molina will pay for a Covered Service less any required Member Cost Sharing.

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

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

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

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

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

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

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

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

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

"**Certified Nurse Midwife**" means 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**" means 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" means 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**" is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina Healthcare has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

"**Copayment**" is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

"**Cost Sharing**" is the Deductible, Copayment, and/or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

"**Covered Service**" or "**Covered Services**" refers to the healthcare services, including supplies and prescription drugs, that You are entitled to receive from Molina under this Agreement.

"**Cytological Screening**" means 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**" is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).
Please refer to the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC) to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

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

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

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

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

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in this EOC.

The following family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren generally do not qualify as Dependents of the Subscriber unless added as a newborn child of a covered Dependent child or of a Member covered by Child-Only Coverage under this Agreement. Coverage for children of a covered Dependent child or of a Member under a Child-Only Coverage will end when the covered Dependent child or Member under a Child-Only Coverage is no longer eligible under this Agreement.

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

"**Drug Formulary**" is Molina Healthcare's list of approved drugs that doctors can order for You.

"**Durable Medical Equipment**" is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to You in the absence of illness or injury and does not include accessories primarily for Your comfort or convenience. Examples include, without limitation: oxygen equipment, blood glucose monitors, apnea monitors, nebulizer machines, insulin pumps, wheelchairs and crutches.
"**Emergency**" or "**Emergency Medical Condition"** means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person

"**Emergency Services**" mean health care procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably 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;
- Serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part;
- or disfigurement to a person

"**Essential Health Benefits**" or "**EHB**" means a standardized set of essential health benefits that are required to be offered by Molina Healthcare to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services. This includes behavioral health treatment
- Prescription drugs
- Rehabilitative and Habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including dental***** and vision care for Members under the age of 19

*****Pediatric dental services are not covered under this EOC. These dental services can be separately provided through a stand-alone dental plan that is certified by the Marketplace.

"**Experimental or Investigational**" means drugs, devices, medical treatments, or procedures that have not been approved by the federal Food and Drug Administration (FDA) where:

- The Drug or device cannot be lawfully marketed without approval of the FDA. Approval for marketing has not been given at the time the drug or device is furnished.
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis. Except as required by 13.10.13.10 NMAC, the drug or device is used for a purpose that is not approved by the FDA.

"**FDA**" means the United States Food and Drug Administration.

"**Health Care Facility**" means an institution providing health care services. This can include a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center, a home health agency; a diagnostic, laboratory, or imaging center; and a rehabilitation or other therapeutic health setting.

"**Independent Social Worker**" means 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" means a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of New Mexico buy qualified health plan coverage from insurance companies or health plans such as Molina Healthcare. The Marketplace may be run as a state-based marketplace, a federally-facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State of New Mexico.

"**Medically Necessary"** or "**Medical Necessity**" means health care services determined by a provider, in consultation with Molina Healthcare, to be appropriate or necessary, according to:
(a) any applicable generally accepted principles and practices of good medical care;
(b) practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
(c) any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional

"**Member**" (also "You" or "Your") means an individual who is eligible and enrolled under this Agreement, and for whom We have received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21. In which case, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Agreement but will not be a Member.
"**Molina Healthcare of New Mexico, Inc. (also "Molina Healthcare" or "Molina", "We", or "Our" or "Us")**" means the corporation licensed in the state of New Mexico as a Health Maintenance Organization, and contracted with the Marketplace.

"**Molina Healthcare of New Mexico Agreement and Individual Evidence of Coverage**" (also "Agreement" or "EOC") means this document, which has information about Your benefits.

"**No charge, deductible applies**", please see Deductible in the definitions section of this document.

"**Non-Participating Provider"** refers to those physicians, hospitals, and other providers that have not entered into contracts to provide Covered Services to Members.

"**Obstetrician-gynecologist**" or "**OB/GYN**" means a physician who is board eligible or board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

"**Other Practitioner**" refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians. Other Practitioners may include Physician Assistants, Certified Nurse Practitioners, and other primary care practitioners who, within the scope of their license, supervise, coordinate, and provide initial and basic care to covered persons, and who maintain continuity of patient care. Other Practitioners also may include Practitioners of the Healing Arts, Doctors of Oriental Medicine, Certified Nurse Midwives, Registered Lay Midwives, and Independent Social Workers.

"**Participating Provider**" refers to those duly licensed hospitals, physicians or other health care professional (including, Practitioners of the Healing Arts, Doctors of Oriental Medicine and other Practitioners) or Health Care Facility authorized to furnish health care services within the scope of their licenses that have entered into contracts to provide Covered Services to Members through this product offered and sold through the Marketplace.

"**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)

"**Premiums**" mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

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

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

"Primary Care Provider" ("PCP") means: a health care professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care practitioners shall include but not be limited to general practitioners, family practice physicians, internists, pediatricians, and obstetricians-gynecologists, physician assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other health care professionals may also provide primary care.

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

"**Registered Lay Midwife**" means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

"**Screening Mammography**" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons and includes the x-ray examination of the breast using equipment that is specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery or less than one radiation mid-breast. Screening mammography includes two views for each breast. Screening mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

"**Service Area**" means the state of New Mexico. Molina Healthcare has been authorized by the New Mexico Office of Superintendent of Insurance to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

"**Specialist Physician**" means
a physician or non-physician health care professional who:
(a) focuses on a specific area of physical or behavioral health or a specific group of patients; and
(b) has successfully completed required training and is recognized by the state in which the health care professional practices to provide specialty care.

"**Spouse**" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual contract, the person in whose name the contract is issued.

"**Subscriber**" means either: means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual contract, the person in whose name the contract is issued.

"**Surprise Bill**" means
(1) a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:
(a) emergency care provided by the nonparticipating provider; or
(b) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where:
1) a participating provider is unavailable;
2) a nonparticipating provider renders unforeseen services; or
3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render
(2) does not mean a bill:
(a) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or
(b) received for health care services rendered by a nonparticipating provider to a covered person
whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care or for services rendered pursuant to Subparagraph (b) of Paragraph (1) of this subsection."

"**Surprise Billing**" may occur when You receive a bill from a Non-Participating Provider that exceeds Your cost-sharing obligation for the Covered Service in one of the two following situations:

- You go to a Non-Participating Provider for Emergency care, excluding ambulance transportation; or
- You 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 You did not give specific consent for that Non-Participating Provider to render the particular services rendered.

"**Surprise Bill Reimbursement Rate**" means 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.

"Telehealth and Telemedicine Services" means the use by a health care professional of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member's medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as "Store and Forward" technology). Requirement: When using "Store and Forward" technology, all covered services must also include an in-person office visit to determine diagnosis or treatment."

"**Urgent Care Services"** means medically necessary health care services provided in an Emergency or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention.

"**Urgent Care Situation"** means 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:

(a) the life or health of the covered person would otherwise be jeopardized;
(b) the covered person's ability to regain maximum function would otherwise be jeopardized;
(c) 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;
(d) the medical exigencies of the case require expedited care; or
(e) the covered person's claim otherwise involves urgent care.

ELIGIBILITY AND ENROLLMENT

When Will My Molina Membership Begin?

Your coverage begins on the Effective Date. The Effective Date is the date You meet all enrollment and Premium pre-payment requirements. It is the date You are accepted by Molina Healthcare and/or the Marketplace.

For coverage during the calendar year 2020, the initial open enrollment period begins November 1, 2019 and ends December 15, 2019. Your Effective Date for coverage during 2020 will depend on when You applied:

- If You applied on or before December 15, 2019, the Effective Date of Your coverage is January 1, 2020.
- Applications made after December 15, 2019 are subject to Special Enrollment Period requirements and verification.
- If You do not enroll during an open enrollment period, You may be able to enroll during a special enrollment period. You must be eligible under the special enrollment procedures established by the Marketplace and/or Molina and Your reason for eligibility must be verified with documentation that is acceptable to the Marketplace and/or Molina. In such case, the Effective Date of coverage will be determined by the Marketplace. The Marketplace and Molina will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

The Effective Date for coverage of new Dependents is described below in the section titled "Adding New Dependents".

Who is Eligible?

To enroll and stay enrolled You must meet all of the eligibility requirements. These are set by the Marketplace. Check the Marketplace's website at healthcare.gov for these requirements. For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. If You have lost Your eligibility, You may not be able to re-enroll. This is described in the section titled "When Will My Molina Membership End? (Termination of Covered Services)."

Molina Healthcare of New Mexico may not restrict You or Your eligible Dependents who are enrolled in this Policy from seeking medical treatment with a non-participating provider. However, should You or Your eligible Dependents who are enrolled in this Policy obtain medical treatment with a nonparticipating provider You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum for any of these services.

Molina shall not restrict PCPs, in consultation with Us, from referring Members to providers outside Our network, even when geographically distant from the Member's residence, when access to such treatment by such provider is Medically Necessary and no other provider can provide comparable treatment in-network or on a more cost-effective basis.

For exceptions please review the following sections of the Agreement titled "Emergency Services and Urgent Care Services", and "What if There Is No Participating Provider to Provide a Covered Service?"

Dependents: Subscribers who enroll during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents. This is established by the Marketplace. Dependents must meet the eligibility requirements. Dependents must obtain services in Our Service Area for this Agreement with the exception of emergent or urgent services. The following family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren generally do not qualify as Dependents of the Subscriber unless added as a newborn child of a covered Dependent child or of a Member covered by Child-Only Coverage under this Agreement. Coverage for children of a covered Dependent child or of a Member under a Child-Only Coverage will end when the covered Dependent child or Member under a Child-Only Coverage is no longer eligible under this Agreement.

Domestic Partners: If permitted by the Marketplace, a domestic partner of the Subscriber may enroll in this product. The domestic partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace .and/or Molina.

A Domestic Partnership is two people of the same or opposite sex who live together and share a domestic life, but aren't married or joined by a civil union.

Age Limit for Disabled or Handicapped Children: Children who reach age 26 are eligible to continue enrollment as a Dependent for coverage if each of the following conditions apply:

- The child is incapable of self-sustaining employment due to mental retardation or physical handicap.
- The child is chiefly dependent upon the Subscriber for support and maintenance.

Molina will provide the Subscriber with notice at least 90 days before the enrolled child reaches the limiting age. At this time, the Dependent child's coverage will end. The Subscriber must give Molina proof of his or her child's incapacity and dependence. This must happen within 31 days of receiving such notice from Molina. This must occur in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina Healthcare. Molina Healthcare may require annual proof of continued incapacity and dependency, following the two-year period after the child's attainment of age 26.

A disabled child may remain covered by Molina as a Dependent. This applies as long as he or she remains incapacitated. The child must initially meet and continue to meet the above-described eligibility criteria described.

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after You as the Subscriber are enrolled (such as a new Spouse, a newborn child, newly adopted child, Foster Child, or a child only dependent), You must contact the Marketplace and submit any required application(s), forms and requested information for the Dependent.

Requests to enroll a new Dependent must be submitted to the Marketplace within 60 days from the date the Dependent became eligible to enroll with Molina Healthcare.

Spouse: You can add a Spouse as long as You apply during the open enrollment period.
You can also apply no later than 60 days after any event listed below:

- The Spouse loses "minimum essential coverage" through:
  - Government sponsored programs,
  - Employer-sponsored plans,
  - Individual market plans, or
  - Any other coverage designated as "minimum essential coverage" in compliance with the Affordable Care Act.
- The date of Your marriage. The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.
- The Spouse permanently moves into the service area.

Children Under 26 Years of Age: You can add a Dependent under the age of 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

- The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act.
- The child becomes a Dependent through marriage, birth, placement in foster care, adoption, placement for adoption, child support, or other court order.
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
- The child permanently moves into the service area.

Newborn Child: Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within 60 days, the newborn is covered, and eligible claims will be processed for payment, for only 31 days (including the date of birth).

> **Please note**: claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and Annual Out-of-Pocket Maximum. However, if an enrollment file is received for the newborn during the first 31 days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or Annual Out-of-Pocket Maximum (i.e. not under the enrolled mother's Deductible and Annual Out-of-Pocket Maximum).

Adopted Child: A newly adopted child or child placed with You or Your Spouse for adoption is covered from whichever date is earlier:

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

If You do not enroll the adopted 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 adoption, placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier. For purpose of this requirement, "legal right to control health care" means You or Your Spouse have:

- A signed written document. This can be:
    - a health facility minor release report
    - a medical authorization form, or
    - a relinquishment form) or
    - Other evidence that shows You or Your Spouse has the legal right to control the child's health care.

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.

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

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

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

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

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

- A signed written document. This can be:
    - a health facility minor release report
    - a medical authorization form, or
    - a relinquishment form) or

- Other evidence that shows You or Your Spouse has the legal right to control the child's health care.

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

Discontinuation of Dependent Covered Services: Covered Services for Your Dependent will be discontinued on:

- The end of the calendar year that the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children Age Limit for Disabled or Handicapped Children".
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage from the Subscriber.
- The end of the calendar year that the child only Member is no longer eligible.

Continued Eligibility: A Member is no longer eligible if:

- The Member becomes abusive or violent and threatens the safety of anyone who works with Molina Healthcare, including Participating Providers.
- The Member substantially impairs the ability of Molina Healthcare, or anyone working with Molina Healthcare, including Participating Providers, to provide care to the Member or other Members.
- There is a breakdown in the Member's relationship with the Member's doctor and Molina does not have another doctor for the Member to see. This may not apply to Members refusing medical care.

If You are no longer eligible for this Agreement, We will send You a letter letting You know at least 30 days before the effective date on which You will lose eligibility. At that time, You can appeal the decision.

MEMBER IDENTIFICATION CARD

You get a Member identification card (ID card) from Molina Healthcare. We will issue an ID card within 10 business days after You make your first payment. Carry Your ID card with You at all times. You must show Your ID card every time You get health care.

If You lose Your ID card, you can get a temporary ID card at mymolina.com and you can get a new ID card by calling Molina Healthcare toll-free at 1-888-295-7651. We will be happy to send You a new ID card.

If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1-888-295-7651.

What Do I Do First?

Look at Your Molina Healthcare Member ID card. Check that Your name and date of birth are correct. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- Molina Healthcare's 24 hours Nurse Advice Line toll-free number 1 (888) 275-8750.
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription related questions CVS Caremark Pharmacy Help Desk : 1 (800) 364-6331

- Toll free number for emergency rooms to notify Molina Healthcare of emergency room admissions for Our Members Emergencies (24 hrs.): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
- If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1-888-295-7651.

Your ID card is used by health care providers such as Your Primary Care Doctor, pharmacist, hospital and other health care providers to determine Your eligibility for services through Molina Healthcare. When accessing care You may be asked to present Your ID card before services are provided.

ACCESSING CARE

How Do I Get Medical Services Through Molina Healthcare?

(Choice of Doctors and Providers; Facilities)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHO OR WHAT GROUP OF PROVIDERS' HEALTH CARE SERVICES MAY BE OBTAINED.

Your Provider Directory includes a list of the Primary Care Providers and hospitals that are available to You as a Member of Molina Healthcare. You may visit Molina's website at MolinaMarketplace.com to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy.

The first person You should call for any health care is Your Primary Care Provider.

If You need hospital or similar services, You must go to a Health Care Facility that is a Participating Provider. For more information about which facilities are with Molina or where they are located, call Molina toll-free at 1-888-295-7651. You may get Emergency Services or out of area Urgent Care Services in any emergency room or Urgent Care center.

Except for Emergency Services, Urgent Care Services, services Molina has Prior Authorized or if You have been referred, by Molina, to a non-Participating Provider in error, You must receive Covered Services from participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to Your Deductible or Your Out-of-Pocket Maximum.

This chart is to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. The right side tells You who to call or where to go.

ALWAYS CONSULT YOUR PRIMARY CARE PROVIDER FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACEESS SPECIALIST OR OTHER PRACTITIONER CARE.	
Type of help You need:	**Where to go. Whom to Call.**
Emergency Services	Call 911 or go to the nearest emergency room. Even when outside Molina Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.
Urgent Care Services	Call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537 for directions. For Urgent Care Services you may also go to the nearest Urgent Care center or emergency room.

ALWAYS CONSULT YOUR PRIMARY CARE PROVIDER FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACEESS SPECIALIST OR OTHER PRACTITIONER CARE.	
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: Pregnancy tests Birth control Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
To see an OB/GYN (woman's doctor)	Women may go to any Participating Provider OB/GYN without a referral or Prior Authorization. Ask Your doctor or call Molina Healthcare's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation.	Go to a mental health Participating Mental Health or Substance Abuse Provider. You do not need a referral or Prior Authorization to get a mental health or substance abuse evaluation
For mental health or substance abuse therapy	For mental health or substance abuse therapy, You do not need a referral or Prior Authorization from Your Participating Provider.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. If You need Emergency Services or Urgent Care Services, refer to the Emergency Care or Urgent Care Services section for details.
To have surgery	Go to Your PCP first. If You need Emergency Services or Urgent Care Services, refer to the Emergency Care or Urgent Care Services section for details.
To get a second opinion	Consult Molina's Provider Directory. You go to Our website at MolinaMarketplace.com to find a Participating Provider for a second opinion.
To go to the Hospital	Go to Your PCP first. If You need Emergency Services or Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
After-hours care	You can also call Molina Healthcare's Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537. You also have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free 1(888) 295-7651. If You are deaf or hard of hearing, You may contact Us by dialing 7-1-1 for the Telecommunications Relay Service.

What is a Primary Care Provider?

A Primary Care Provider (or PCP) takes care of Your health care needs. A PCP knows You well. Call Your PCP when You are sick and You do not know what to do. You do not have to go to the emergency room unless You believe You have an Emergency Condition.

You may think that You should not see Your PCP until You are sick. That is not true.

Get to know Your PCP even when You are well. Go for yearly check-ups to stay healthy. Go to Your PCP for check-ups, tests and test results, shots, and when You are ill. Seeing Your PCP for check-ups allows problems to be found early. If You need special care, Your PCP will help You get it. Your PCP and You work together to keep You healthy.
If You want to know more about Your PCP or other Molina Healthcare doctors, call Us. Molina's Customer Support Center number is toll-free at 1 (888) 295-7651.

Choosing Your Doctor (Choice of Physician and Providers)

For Your health care to be covered under this Agreement, Your health care services must be provided by Molina Healthcare Participating Providers (doctors, hospitals, specialist physicians or medical clinics), except in the case of Emergency Services. Please see "Emergency Services and Urgent Care Services" for more information.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and hospitals that are available under Molina's health plan. You will also learn some helpful tips on how to use Molina services and benefits. Visit Molina's website at MolinaMarketplace.com and click Find a Doctor or Pharmacy for more information.

You can find the following in Molina's Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations Professional qualifications (e.g. board certification)
- You can also find out if a Participating Provider is taking new patients. This includes doctors, hospitals, specialist physicians, or medical clinics.
- You can also find out if a Participating Provider, including doctors, hospitals, specialist physicians, or medical clinics, is accepting new patients in Your Provider Directory.

Note: Some hospitals and providers may not provide some of the services that may be covered under this EOC that You or Your family member might need. This may include family planning, birth control, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should get more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1- 888-295-7651 to make sure that You can get the health care services that You need.

How Do I Choose a Primary Care Provider (PCP)?

It is easy to choose a Primary Care Provider (or PCP). Use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or, You may want to choose one doctor for Your and another one for Your family members.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You feel comfortable with the PCP You choose.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina Healthcare toll-free at 1 (888) 295-7651. Molina Healthcare can also help You find a PCP. Tell Us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your doctor.

What if I Don't Choose a Primary Care Provider?

Molina asks that You select a Primary Care Provider within 30 days of joining Molina.

Refer to "How do I Change my Primary Care Provider?" section to change your provider if one is suggested for you and you would like to change the selection. You can also call Molina Healthcare toll-free at 1 (888) 295-7651. We are here Monday through Friday, 8:00 a.m. to 5:00 p.m., MT. You may also visit Molina's website at MolinaMarketplace.com to view Our online list of doctors.

Freedom of Choice of Participating Providers Within Service Area

When seeking Covered Services under this EOC, You have the right to full freedom of choice in choosing:

- A hospital for hospital care which is covered under this EOC, or
- A Practitioner of the Healing Arts or optometrist, psychologist, podiatrist, Physician Assistant, Certified Nurse Midwife, Registered Lay Midwife, registered nurse or Independent Social Worker for Covered Services within that person's scope of practice, so long as such hospital, practitioner or other health care provider is a Participating Provider and located within the Service Area.
- This provision does not mean that Molina is contracted with every type of Health Care Facility or health care practitioner at any given time. Please consult Your Provider Directory on Our website at MolinaMarketplace.com to find a Participating Provider in the Service Area.

CHANGING YOUR DOCTOR

What if I Want to Change my Primary Care Provider?

You can change Your PCP at any time. All changes made by the 20th of the month will be in effect on the first day of the next calendar month. All changes made on or after the 20th of the month, the effective date will be the first day of the second calendar month. First visit Your doctor. Get to know Your PCP before changing. A good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina doctor.

Can my Primary Care Provider request that I change to a different Primary Care Provider?

Your Primary Care Provider may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor-patient relationship breakdown

How do I Change my Primary Care Provider?

Call Molina Healthcare toll-free at 1 (888) 295-7651. We are here Monday through Friday, 8:00 a.m. to 5:00 p.m., MT. You may also visit Molina's website at.MolinaMarketplace.com to view Our online list of doctors. Let Us help You make the change.

Sometimes You may not be able to get the PCP You want. This may happen because:

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

What if my doctor or hospital is not with Molina?

If You are new to Molina and are currently in an active on-going course of treatment with a doctor or a hospital, which is not a Participating Provider, You may be able to continue those services covered for a transition period of not less than 30 days. Members with certain conditions, including Members in their third trimester of pregnancy, may submit a request for a transition of care to Molina within 30 days of enrollment. For those Members in their third trimester, the transitional period will continue through delivery, including post-partum care related to delivery.

For existing Members, if Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina, we will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. If You want a different doctor, You can choose one. Our Customer Support Center staff can help You make a choice.

(1) 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.
(2) Molina shall assist such affected covered Members in locating and transferring to another similarly qualified provider.
(3) 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.

If You are assigned to a PCP or hospital or are seeing a provider on a regular basis, whose contract with Molina is ending, then Molina will provide You with not less than 30 days advance written notice of such a contract ending. Transition of care services may be available for existing Members with certain medical conditions and those in their second or third trimester of pregnancy. This is so they can have continued access to their doctor or hospital if the doctor’s or hospital’s contract with Molina ends. This includes coverage of post-partum care related directly to the delivery.

Molina makes transition of care determinations for new and existing Members based on established criteria. The transitional period will not be less than 30 days.

If You want to request that You stay with the same doctor or hospital for continuity of care, call Molina Healthcare’s Customer Support Center toll-free at 1 (888) 295-7651. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 659-833. You may also dial 711 for the Telecommunications Service. You can also ask for a copy of Molina’s policy that talks about staying with a doctor or hospital.

Continuity of Care

If You are receiving active treatment for covered services from a Participating Provider, who's participation with Molina is ending without cause, You may have a right to continue receiving covered services from that provider until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing.

An "Active Course of Treatment" is:

1. An ongoing course of treatment for a life-threatening condition;
2. an ongoing course of treatment for a serious acute condition;
3. the second or third trimester of pregnancy; or
4. 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

A "Serious Acute Condition" is:

- a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy.

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

- Upon successful transition of care to a Participating Provider
- Upon completion of the course of treatment prior to the 90th day of Continuity of Care
- After the 90th day of Continuity of Care
- If You have exceeded the benefit limits under Your plan
- If care is not medically necessary
- If care is excluded from your coverage
- If you become ineligible for coverage

We will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition. Unless otherwise required by law, Molina will reimburse the provider up to the previously contracted amount for such service. You may be responsible to the provider for any billed amounts that exceed the amount paid by Molina under this section. That would be in addition to any in-network cost-sharing amounts that You owe under this EOC. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Your Deductible or Your Annual Out-of-Pocket Maximum.

We will not provide coverage for services not otherwise covered under this EOC.

Transition of Care

If You are new to Molina, We may allow You to continue receiving Covered Services for an ongoing course of treatment with a Non-Participating Provider until we arrange transition of care to a Participating Provider, under the following conditions:

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

2. Molina provides Covered Services on or after Your effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina), may be responsible for coverage until Your coverage is effective with Molina.

3. After Your effective date with Molina, We may coordinate the provision of Covered Services with any Non-Participating Provider (physician or hospital) on Your behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

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

What If There Is No Participating Provider to Provide a Covered Service?

If there is no Participating Provider that can provide a non-Emergency Covered Service, We will provide the Covered Service through a Non-Participating Provider in the same manner as and at no greater Cost than the same Covered Services when rendered by Participating Providers, provided You obtain Prior Authorization before the initiation of the service. In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances.

24-Hour Nurse Advice Line

If You have questions or concerns about You or Your family's health, call Our 24-Hour Nurse Advice Line at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537. If You are deaf or hard of hearing, You can access Nurse Advice with the Telecommunications Service. Call by dialing 711. Registered Nurses staff the Nurse Advice Line. They are open 24 hours a day, 365 days a year.

Telehealth and Telemedicine Services

You may obtain Covered Services that are provided through telehealth, except as specifically stated in this agreement. In-person contact between You and the doctor is not required for these services, and the type of setting where these services are provided is not limited. .For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email only
- Member Cost Sharing is shown in Your Summary of Benefits and Coverage.
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment. Please refer to the "Definition" section for explanation.

Your doctor's office should give You an appointment for the listed visits in this time frame:

Appointment Type For PCPs	When You should get the Appointment
Urgent care for Covered Services	Within 48 hours of the request
Routine or non-urgent care	As soon as practical, this depends on Your medical needs. It also depends on the Provider's practice.
Non-urgent care with a non-physician. Behavioral health care provider	As soon as practical, this depends on Your medical needs. It also depends on the Provider's practice.
Appointment Type For Specialist Physicians	When You should get the Appointment
Urgent care for Covered Services	Within 48 hours of the request
Routine or non-urgent care	As soon as practical, this depends on Your medical needs. It also depends on the Provider's practice.

PRIOR AUTHORIZATION

What is a Prior Authorization?

A **Prior Authorization** is a pre-service determination made by Molina regarding a Member' covered person'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. Molina's Medical Directors and Your doctor work together to determine the Medical Necessity of covered services before the care or service is given. This is sometimes also called a prior approval.

Note: Approvals are given based on Medical Necessity. You or Your Participating Provider may call for Prior Authorization; however, You are ultimately responsible for ensuring that Prior Authorizations are requested when required. If You have questions about how a certain service is approved, call Molina Healthcare toll-free at 1 (888) 295-7651. If You are deaf or hard of hearing, call the TTY line 711 for the Telecommunications Relay Service.

For Prior Authorization requirements for prescription drugs, please see the Prescription Drug Coverage section of this Agreement.

You do not need Prior Authorization for the following services:

- Approved Clinical Trials
- Diagnosis or treatment plan for Autism Spectrum Disorder*
- Dialysis (One time notification is requested; Prior Authorization is not required; please notify Molina before services are rendered by calling 1(888) 295-7651
- Emergency or Urgent Care Services
- Family planning services
- Gynecological or obstetrical ultrasound procedures
- Hospice inpatient care (notification only; Prior Authorization is not required; please notify Molina before services are rendered by calling 1(888) 295-7651
- Human Immunodeficiency Virus (HIV) testing & counseling
- Mental health outpatient services:

    - Day Treatment
    - Individual and group mental health evaluation and treatment
    - Evaluation of Mental Disorders
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- Office - based procedures
- Pregnancy and delivery (notification only; Prior Authorization is not required; please notify Molina before services are rendered by calling 1 (888) 295-7651
- Services for sexually transmitted diseases
- Substance abuse outpatient services:
    - Day Treatment
    - Individual and group substance abuse counseling
    - Medical treatment for withdrawal symptoms
    - Individual substance abuse evaluation and treatment
    - Group substance abuse treatment,
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- To see an OB/GYN (Women may self-refer)

* Some autism therapies require a Prior Authorization. Please call our Customer Support Center at 1(888) 295-7651 for more information.

You must get Prior Authorization for the following services, except for Emergency Services or Urgent Care Services:

- Admission in a hospital or ambulatory care center for dental care.
- All inpatient admissions
- Any kind of wheelchair
- Bariatric surgery
- Certain Ambulatory Surgery Center service (ASC)*
- Certain Durable Medical Equipment*
- Certain injectable drugs And medications not listed on the Molina Drug Formulary*
- Certain outpatient hospital service*
- Cosmetic, plastic and reconstructive procedures (in any setting)
- Custom orthotics, custom prosthetics, and braces. Examples are:
    - Shoes or shoe supports
    - Special braces
- Drug quantities that exceed the day-supply limit
- Experimental and Investigational procedures
- Gene therapy – (most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies subject to Prior Authorization)
- Genetic counseling and treatment
- General anesthesia for dental care in Members 5 years old or older
- Habilitative Services – After 1 evaluation and 24 visits in an outpatient setting
- Home health care - After 7 visits
- Hyperbaric Therapy
- Imaging and special tests Examples are:

    - CT (computed tomography)
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiogram)
    - PET (positron emission tomography) scan
    - Digital breast tomosynthesis (3D mammography)
- Implanted hearing device
- Low vision follow-up care
- Mental Health Services*
    - Electroconvulsive Therapy (ECT),
    - Mental Health Inpatient,
    - Neuropsychological and psychological testing,
    - Transitional substance abuse residential treatment
    - Partial hospitalization
- Pain management care and procedures, except trigger point injections
- Pregnancy and delivery (notification only)
- Radiation therapy and radio surgery
- Rehabilitative services
    - Cardiac and pulmonary rehabilitation
    - Occupational Therapy (After initial evaluation and 23 visits/year in outpatient and home settings)
    - Physical Therapy (After initial evaluation and 23 visits/year in outpatient and home settings)
    - Speech Therapy (After 6 visits for outpatient and home settings)
- Scooters
- Services Rendered by a Non-Participating Provider
- Sleep Studies (except home sleep studies)
- Certain specialty pharmacy drugs (oral and injectable)
- Substance Abuse Services:
    - Inpatient Services
    - Partial hospitalization
    - Detoxification Services
    - Transitional substance abuse residential treatment
- Surgery or other procedures to correct diagnosed infertility. This is subject to "Exclusions" from coverage.
- Transplant evaluation and related service including Solid Organ and Bone Marrow (Cornea transplant does not require a Prior Authorization)
- Transportation. This is for non-emergent ground and air ambulance. Must be medically necessary. Examples are a special vans service or ambulance.
- Unlisted and miscellaneous medical codes or any other services listed as needing Prior Authorization in this EOC.
- Wound Therapy

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

Molina Healthcare might deny a request for a Prior Authorization. You may appeal that decision as described below. If You and Your provider decide to proceed with service that has been denied You may have to pay the cost of those services.

Approvals are given based on Medical Necessity. All determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed 24

hours for emergency care and seven days for all other determinations. If Molina is unable to complete a referral within ten days due to unforeseen circumstances, Molina shall inform You in writing about the reasons for the delay and when a decision may be expected. If Molina does respond to a request within these time frames, the request is deemed to be approved.
You will be sent a written notice of all determinations to deny coverage or authorization for health care services, which shall contain the reasons why coverage or authorization was denied. This written notice will also contact a full explanation of Your grievance and appeal rights, including the right to request an internal review from Molina.

We are here to help you, if You have questions about how a certain service is approved, call us. The number is 1 (888) 295-7651. If You are deaf or hard of hearing, call Our TTY line. That number is toll-free at 1 (800) 659-8331. You can dial 711 for the Telecommunications Service.

We can explain to You how that type of decision is made. We will send You a copy of the approval process if You request it.

Routine Prior Authorization requests will be processed within five business days. This is five days from when we get the information we need and ask for. We need this information to make the decision. It may take up to 14 calendar days from the receipt of the request. We will deny Prior Authorization requests if You do not provide the information We requested.

We process Prior Authorizations for medical conditions that may cause a serious threat to Your health within 24 hours. This is 24 hours from when we get the information we need and ask for. We need this information to make the decision. We will deny a Prior Authorization if information We request is not provided to Us. The time required may be shorter under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations.

If a service request is not Medically Necessary it may be denied. If it is not a Covered Service it may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are in the section “Member Grievance and Appeal Procedure”.

Standing Approvals

You may have a condition or disease that requires special medical care over a long period of time. You may need a standing approval. Your condition or disease may be life threatening. It may worsen. It could cause disability. If this is true You may need a standing approval to a specialist physician. You may need one for a specialty care center. They have the expertise to treat Your condition.

To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina’s doctors and specialist physicians to be sure Your treatment plan meets Your medical needs. If You have trouble getting a standing approval, call Us. The number is toll-free 1(888) 295-7651. For deaf or hard of hearing call Our dedicated TTY line. That toll-free number is 1 (800) 659-8331. You may also dial 711 for the Telecommunications Service.

If You feel Your needs have not been met please see Molina’s grievance process These instructions are in the section “Member Grievance and Appeal Procedure”.

Second Opinions

You or Your PCP may want a second doctor to review Your condition. This can be a PCP or a specialist physician. This doctor looks at Your medical record. The doctor may see You at their office. This new doctor may suggest a plan of care. This is called a second opinion. Please consult Your Provider Directory on Our website. You can find a Provider for a second opinion. The website is MolinaMarketplace.com and click Find a Provider.

Here are some reasons why You may get a second opinion:

- Your symptoms are complex or confusing.
- Your doctor is not sure the diagnosis is correct.
- You have followed the doctor's plan of care and Your health has not improved.
- You are not sure if You need surgery.
- You do not agree with what Your doctor thinks is Your problem.
- You do not agree with Your doctor's plan of care.
- Your doctor has not answered Your concerns about Your diagnosis or plan of care.
- There may be other reasons. Call Us if You have questions.

EMERGENCY AND URGENT CARE SERVICES

What is an Emergency?

Emergency Services means health care procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably 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;
- Serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part;
- or disfigurement to a person

Emergency Services also includes Emergency contraceptive drug therapy.

How do I get Emergency Care?

Emergency care is available 24 hours a day, seven days a week for Molina Members.

If You think You have an Emergency:

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

When You go for Emergency health care services, bring Your Molina Member ID card.

If You are not sure if You need Emergency care but You need medical help, call Your PCP. Or call Our 24-Hour Nurse Advice Line toll-free.

- English - 1 (888) 275-8750
- Spanish - 1 (866) 648-3537.

The Nurse Advice Line is staffed by registered nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing please use the Telecommunications Service by dialing 711.

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

If You are away from Molina Healthcare's Service Area need Emergency Care?

Go to the nearest emergency room for care. Please contact Molina within 24 hours or as soon as You can. Call toll-free at 1 (888) 295-7651. If You are deaf or hard of hearing, call Our TTY line toll-free at 1 (800) 659-8331. When You are away from Molina's Service Area only Emergency Services are covered.

What is an Urgent Care Situation?

"Urgent care situation" means 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:

(a) the life or health of the covered person would otherwise be jeopardized;
(b) the covered person's ability to regain maximum function would otherwise be jeopardized;
(c) 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;
(d) the medical exigencies of the case require expedited care; or
(e) the covered person's claim otherwise involves urgent care.

What if I need after-hours care or Urgent Care Services?

Urgent Care Services are subject to the Cost Sharing in the Summary of Benefits and Coverage (SBC). Urgent Care Services are available when You are within or outside of Molina's Service Area. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services call Your PCP or Molina's 24-Hour Nurse Advice Line. The number is toll-free.

- English 1 (888) 275-8750
- Spanish 1 (866) 648-3537

Our nurses can help You any time of the day or night. They will help You decide what to do. They can help You decide where to go to be seen.

If You are within Molina's Service Area You can ask Your PCP what Urgent Care center to use. It is best to find out the name of the Urgent Care center ahead of time. Ask Your doctor for the name of the Participating Provider urgent care center and the name of the hospital that You are to use.

You have the right to interpreter services at no cost. To help in getting after hours care call toll-free at 1 (888) 665-4621.
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Emergency Services by a Non-Participating Provider

Emergency Services for treatment of an Emergency Medical problem are subject to Cost Sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Summary of Benefits and Coverage (SBC).

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, Molina will calculate the Allowed Amount 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.

Please note You are not responsible for payment to the Non-Participating Provider for amounts in excess of Your applicable Deductible, Copayment, and/or Coinsurance for the Emergency Services. If You receive a bill for Emergency Services, other than a bill for Your applicable Deductible, Copayment, and/or Coinsurance for the Emergency Services, please contact Molina's Customer Support Center for assistance at 1- (888) 295-7651.

Non-Emergency Services Provided by a Non-Participating Provider in a Participating Provider Health Care Facility

Molina will pay for Covered Services which have a Prior Authorization. See the section titled "Prior Authorization."

Molina will pay for Covered Services rendered by a Non-Participating Provider that are delivered when You are at a Participating Provider Health Care Facility and You do not have the ability or opportunity to choose a Participating Provider who is available to provide the Covered Service. The Non-Participating Providers delivering services in a Participating Provider Health Care Facility may include, but are not limited to, pathologists, radiologists, and anesthesiologists. You are still responsible for applicable cost-sharing that would apply if a Participating Provider had rendered the same Covered Services. See Cost-Sharing as detailed in the Summary of Benefits and Coverage (SBC).

Molina will calculate the Allowed Amount that will be covered for Non-Emergency services provided by a Non-Participating Provider in a Participating Provider Health Care Facility in accordance with applicable state law.

Mandatory Transfer to a Participating Provider Hospital

You must have a Prior Authorization to get hospital services, except in the case of Emergency Services. If You get services in a hospital or You are admitted to the hospital for Emergency Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

After stabilization and after provision of transportation to a Participating Provider facility, services provided in an out-of-area or Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments, and the payments will not apply to Your Deductible or Your Annual Maximum Out-of-Pocket.

COMPLEX CASE MANAGEMENT

What if I have a difficult health problem?

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

If You would like information about this program, please call the Customer Support Center toll free. The number is 1 (888) 295-7651. Deaf or hard of hearing members can call Our dedicated TTY line. The number is 1 (800) 659-8331. You may also dial 711 for the Telecommunications Service.

PREGNANCY

What if I am pregnant?

If You are pregnant, or think You are pregnant, or as soon as You know You are pregnant, please call for an appointment to begin Your prenatal care. Early prenatal care is very important for the health and well-being of You and Your baby.

You may choose any of the following for Your prenatal care:

- Licensed Obstetrician-gynecologists (OB/GYNs)
- Certified Nurse Practitioner (trained in women's health)
- Certified Nurse Midwife

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits, You must pick an OB/GYN or Certified Nurse Practitioner who is a Participating Provider.

If You need help choosing an OB/GYN, call Us. If You have any questions, call Molina toll-free at 1 (888) 295-7651. We are here Monday through Friday from 8:00 a.m. to 5:00 p.m. MT. We will be happy to help You.

ACCESS TO CARE FOR MEMBERS WITH DISABILITIES

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits discrimination based on disability. The ADA requires Molina and its contractors to make reasonable accommodations for patients with disabilities.

Physical Access

Molina has made every effort to ensure that Our offices and the offices of Molina doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Us. The toll-free number is 1 (888) 295-7651. Our TTY line number is toll-free at 1 (800) 659-8331. We will help You find another doctor.

Access for the Deaf or Hard of Hearing

If You need a sign language interpreter let Us know. Call Molina Healthcare's Customer Support Center. The TTY Number is toll-free at 1 (800) 659-8331. You may also use the Telecommunications Service by dialing 711.

Access for Persons with Low Vision or who are blind

You can request this EOC and other important plan materials in accessible formats. These are for persons with low vision or who are blind. Large print and enlarged computer disk formats are available. This EOC is also available in an audio format. For accessible formats, or for direct help in reading the EOC and other materials, please call Us Members who need information in large size print, audio, and Braille can ask for it. Call the Customer Support Center. The number is toll-free at 1 (888) 295-7651.

Disability Access Grievances

If You believe Molina or its doctors have failed to respond to Your disability access needs, You may file a grievance by contacting Molina Member Services at (888) 295-7651. For additional information regarding Your right to file a grievance, please refer to the Member Grievance and Appeal Procedure section of this Agreement.

COVERED SERVICES

Molina Healthcare covers the services described in the section titled "What is Covered Under My Plan?" below. These services are subject to the exclusions, limitations, and reductions set forth in this EOC, only if all of the following conditions are satisfied:

- You are a Member on the date that You receive the Covered Services
- Except for preventive care and services, the Covered Services are Medically Necessary
- The services are listed as Covered Services in this EOC
- You receive the Covered Services from Participating Providers inside Our Service Area for this product, except where specifically noted to the contrary in this EOC. In limited circumstances, for example, in the case of Emergency Services and/or Urgent Care Services, You may receive covered services from outside providers.

The only services Molina Healthcare covers under this EOC are those described in this EOC, subject to any exclusions, limitations, and reductions described in this EOC.

COST SHARING (Money You Will Have To Pay To Get Covered Services)

Cost Sharing is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits. The Affordable Care Act requires preventive services. They will be provided by Participating Providers. Cost Sharing for Covered Services is listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members. This is determined by the Marketplace's rules.

For services, such as laboratory and x-ray that are provided on the same date of service as an office visit to a PCP or a specialist, you will only be responsible for the applicable Cost Sharing amount for the office visit.

YOU SHOULD REVIEW THE MOLINA HEALTHCARE OF NEW MEXICO, INC. SUMMARY OF BENEFITS AND COVERAGE (SBC) **CAREFULLY. YOU NEED TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.**

Annual Out-of-Pocket Maximum

Also referred to as **"OOPM"** is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

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

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

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

Coinsurance

Coinsurance is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). Some Covered Services do not have Coinsurance They may apply a Deductible or Copayment.

Copayment

A Copayment is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). Some Covered Services do not have a Copayment. They may apply a Deductible or Coinsurance.

Deductible

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

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

When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

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

General Rules Applicable to Cost Sharing

All Covered Services have a Cost Sharing (i.e deductible, copayment and/or coinsurance), unless specifically stated, or You meet the Annual Out-of-Pocket Maximum. Please refer to the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). You will be able to determine the Cost Sharing amount You will be required to pay for each type of Covered Service listed.

You are responsible for the Cost Sharing in effect on the date You receive Covered Services, except as follows:

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this EOC, You pay the Cost Sharing in effect on Your admission date. You will pay this Cost Sharing until You are discharged. The services must be covered under Your prior health plan evidence of coverage. You must also have had no break in coverage. However, if the services are not covered under Your prior health plan evidence of coverage You pay the Cost Sharing in effect on the date You receive the Covered Services. Also, if there has been a break in coverage, You pay the Cost Sharing in effect on the date You receive the Covered Services.

- For items ordered in advance, You pay the Cost Sharing in effect on the order date. Molina will not cover the item unless You still have coverage for it on the date You receive it. You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order. They must receive all of the information they need to fill the prescription before they process the order.

Receiving a Bill

In most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. This payment may cover only portions of the total Cost Sharing for the Covered Services You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due.

The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this EOC. However, You are responsible for paying charges for any health care services or treatments that are:

- not Covered Services under this EOC or
- provided by a Non-Participating Provider, except that Molina will cover services from a Non-Participating Provider for Emergency Services in accordance with the section of the Agreement titled “Emergency Services and Urgent Care Services”; and for additional exceptions described in the section of this Agreement titled “What if There Is No Participating Provider to Provide a Covered Service?.”

How Your Coverage Satisfies the Affordable Care Act

Your Covered Services include Essential Health Benefits as required by the Affordable Care Act. If non-EHB coverage is included in Your product, those Covered Services will be set out in this EOC as well.

Your Essential Health Benefits coverage includes at least the 10 categories of benefits identified in the definition. You cannot be excluded from coverage in any of the 10 EHB categories. However, You will not be eligible for pediatric services that are Covered Services under this Agreement if You are 19 years of age or older. This includes pediatric dental separately provided through the Marketplace and pediatric vision services.

The Affordable Care Act provides certain rules for Essential Health Benefits. These rules tell Molina how to administer certain benefits and Cost Sharing under this EOC. For example, under the Affordable Care Act, Molina is not allowed to set lifetime limits or annual limits on the dollar value of Essential Health Benefits provided under this EOC. When EHB preventive services are provided by a Participating Provider, You will not have to pay any Cost Sharing amounts. In addition, Molina must ensure that the Cost Sharing, which You pay for all Essential Health Benefits, does not exceed an annual limit that is determined under the Affordable Care Act. For the purposes of this EHB annual limit, Cost Sharing refers to any costs, which a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable

For qualifying Subscribers, there may be assistance to help make the product that You are purchasing under this Agreement more affordable. If You have not done so already, please contact the Marketplace to determine if You are eligible for tax credits. Tax credits may reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits. The Marketplace also will have information about any annual limits on Cost Sharing towards Your Essential Health Benefits. The Marketplace can assist You in determining whether You are a qualifying Indian who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina will work with the Marketplace in helping You.

Molina does not determine or provide Affordable Care Act tax credits.

What is Covered Under My Plan?

This section tells You what medical services Molina covers These are called Your Covered Services. Except for preventive care and services, for a service to be covered **it must be Medically Necessary**.

You have the right to appeal if a service is denied. These instructions are in the section "Member Grievance and Appeal Procedure".

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Molina also may cover routine medical costs for Members in Approved Clinical Trials. Certain medical services described in this section will only be covered by Molina if You obtain Prior Authorization *before* seeking treatment for such services. To read more about Prior Authorization and a complete list of Covered Services which require Prior Authorization, turn to "What is a Prior Authorization?". Prior Authorization does not apply to treatment of Emergency Conditions or for Participating Provider Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

Preventive Care and Services

Preventive Services and the Affordable Care Act

Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services, without Your paying any Cost Sharing:

- 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) with respect to the individual involved. A full list of the USPSTF preventive services can be found at this link: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index;

- Those immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, those evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

All preventive care must be furnished by a Participating Provider to be covered under this Agreement. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement. Coverage will start for product years, which begin one year after the date the recommendation or guideline is issued, or on such other date as required by the Affordable Care Act. The product year, also known as an Agreement year for the purposes of this provision, is based on the calendar year.

Molina Healthcare does not impose coverage limitations on preventive services, other than those services which are specific to certain age groups and/or genders. To help You understand and access Your benefits, preventive services for adults and children that are covered under this EOC are listed below. In addition, a full list of the USPSTF preventive services can be found at this link: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
To help You understand and access Your benefits, preventive services for adults and children that are covered under this EOC are listed below.

Preventive Services for Children and Adolescents

The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay Cost Sharing if services are furnished by a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

Please consult with your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for:

- Alcohol and Drug Use assessments for adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Autism screening for children
- Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Basic vision screening (non- refractive)
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Behavioral health assessment for children
- Cervical dysplasia screening: sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21.These include those with special health care needs.)
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Health management
- Hearing screening
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*****
- Iron supplementation in children when prescribed by a Participating Provider
- Lead blood level testing (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.)
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

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

Preventive Services for Adults and Seniors

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

- Abdominal aortic aneurysm screening: for male former smokers age 65-75
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin for the prevention of preeclampsia
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Bacteriuria screening: pregnant women

- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure screening
- BRCA counseling about breast cancer preventive medication
- Breast cancer and chemoprevention counseling for women at high risk
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies counseling
- Cancer screening
- Cholesterol check
- Chlamydial infection screening: women
- Colorectal cancer screening (based on Your age or increased medical risk. Examples of this screening include colonoscopy, and medically necessary periodic stool examinations.)
- Cytological Screening (pap smear) for women every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology
- Cytologic screening in a hospital or certified lab for the presence of cervical cancer
- Depression screening: adults
- Depression screening: Postpartum women
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling: adults at higher risk for chronic disease
- Dietary evaluation and nutritional counseling
- Exercise to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Healthy diet counseling
- Hearing screenings
- Hepatitis B screening: pregnant women
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations
- Medical history and physical exam
- Obesity screening and counseling: adults
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention
- Prostate specific antigen testing
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women

- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection and pregnant women.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)
- Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
- Screening for osteoporosis for women age 65 years and older
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Statin preventive medication: adults age 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions
    - Screening for tobacco use; and,
    - For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
        - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
- Tuberculosis (TB) screening
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed).

Services of Physicians and Other Practitioners

We cover the following outpatient services when furnished by a Participating Provider physician or Other Practitioner (within the scope of his or her license):

- Audiology and hearing tests
- Consultations and well child care
- Diabetic eye examinations (dilated retinal examinations)
- Diagnosis and medically indicated treatments for physical conditions causing infertility (Benefit covers only testing, diagnosis, and corrective procedure, subject to exclusions in the “Exclusions” section.)
- Injections, allergy tests and treatments when provided by Your PCP
- Office visits (including pre- and post-natal visits)
- 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 as described in “Newborn and Adopted Children Coverage” under this “What is Covered Under My Plan?” section
- Physician and other Practitioner care in or out of the hospital

- Prevention, diagnosis, and treatment of illness or injury
- Routine examinations and prenatal care provided by an OB/GYN to female Members. You may select an OB/GYN as Your PCP. Female Dependents age 13 and older have direct access to obstetrical and gynecological care.
- Routine pediatric and adult health exams
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye. (Benefits are not available for charges connected to routine refractive vision examinations or to the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, "Pediatric Vision Rider.")
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)

Habilitative Services

Medically Necessary habilitative services and devices are health care 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 services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitative Services

We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, speech therapy, and occupational therapy in a setting appropriate for the level of disability or injury, and include cardiac and pulmonary rehabilitation.

Outpatient Mental/Behavioral Health Services

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

- Individual, family and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder (defined below)
- Outpatient services for the purpose of monitoring drug therapy

We cover outpatient mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.
"**Mental Disorders**" include the following conditions:

Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa

Molina covers the screening, diagnosis and treatment of Autism Spectrum Disorder only as provided in this Agreement under 1) "Preventive Care for Children and Adolescents" in the "Preventive Services and the Affordable Care Act" section above, and 2) "Autism Spectrum Disorder" in the "Pediatric Services" section.

Outpatient Substance Abuse Disorder Services

We cover the following outpatient care for treatment of substance abuse:

- Day treatment programs

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

We do not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this Agreement.

DENTAL AND ORTHODONTIC SERVICES

We cover only dental and orthodontic services for Members as described in this section.

Dental Services for Radiation Treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer and other neoplastic diseases in Your head or neck. You must receive services from a Participating Provider physician.

Dental Anesthesia

For dental procedures, we cover general anesthesia and the Participating Provider facility's services associated with the anesthesia if one of the following is true:

- The Member has physical, intellectual, or medically compromising conditions for which treatment under local anesthesia cannot be expected to provide a successful result. In addition, dental treatment under general anesthesia can be expected to produce superior results.
- Members for whom local anesthesia is ineffective because of acute infection, anatomic variation, or allergy.
- Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment cannot be postponed or deferred. In addition, lack of treatment for these children or adolescents can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity. (Children under 5 years of age are not required to meet any of these conditions.)
- Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- Other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.

We do not cover any other services related to the dental procedure, such as the dentist's services.

Dental and Orthodontic Services for Cleft Palate

We cover some dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services. They must meet all of the following requirements:

- The services are integral basic part of a reconstructive surgery for cleft palate.
- A Participating Provider provides the services; or
- Molina authorizes a Non-Participating Provider who is a dentist or orthodontist to provide the services.

Services to Treat Dental Injury Due to Trauma

We cover dental services to treat damage to a sound tooth that does not have significant decay or prior trauma, such as a filling, cap, or crown. The trauma must result from an accidental injury due to an outside force. This includes accidental injury to sound natural teeth, the jaw bones, or surrounding tissues; the correction of a non-dental physiological condition which has resulted in a severe functional impairment; or the treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

We also cover surgery from which an improvement in physiologic function could reasonably be expected, when ordered by a covered person's primary care practitioner or treating health care professional and performed for the correction of functional disorders resulting from accidental injury or from
congenital defects or disease. These services may require a prior authorization. Please contact our Customer Support Center at 1-888-295-7651.

Services to Treat Temporomandibular Joint Syndrome ("TMJ")

We cover the following services to treat temporomandibular joint syndrome (also known as "TMJ"):

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

For Covered Services related to dental or orthodontic care in the above sections, You will pay the Cost Sharing You would pay if the services were not related to dental or orthodontic care. For example, for inpatient hospital services, You would pay the Cost Sharing in the "Inpatient Hospital Services" section of the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

Vision Services

We cover the following vision services for all Members:

- Diabetic eye examinations (dilated retinal examinations)
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye

Benefits are not available for charges connected to routine refractive vision examinations or for the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, "Pediatric Vision Services."

ADULT ROUTINE VISION SERVICES

We cover routine adult vision services for Members over the age of 19 pursuant to the "Adult Vision Services Rider No. 1 Molina Marketplace" which will become part of this Agreement.

PEDIATRIC SERVICES

We cover the following pediatric services for Members whose age qualifies them for such services:

Pediatric Vision Services

We cover pediatric vision services for Members under the age of 19 pursuant to the "Pediatric Vision Services Rider No. 1 Molina Marketplace" which will become part of this Agreement.

Hearing Aids for Dependent Children
We cover hearing aids and certain related services for Dependent children. They must be under 18 years of age. They may be under 21 years of age, if still attending high school. Coverage includes one hearing aid for qualifying Dependent children every 36 months of coverage under this EOC. A hearing aid that costs $2,500 or less is covered at No Charge. You may choose a hearing aid for a Dependent child that costs more than $2,500. You may purchase a hearing aid more frequently than once every 36 months. However, You will pay the excess cost at the Coinsurance Cost-Share indicated on the Summary of Benefits. Dollar amount limits are not applicable to hearing aids for Habilitative or Rehabilitative purposes. These amounts will be counted toward Your Deductible and Your Out-of-Pocket Maximum under this EOC.

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

Hearing Screenings

We cover routine hearing screenings for Members age 18 or younger when performed by a licensed, qualified Participating Provider. These services are provided at no charge.

Autism Spectrum Disorder

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

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

To be covered under this EOC, treatment for Autism Spectrum Disorder must be: 1) Medically Necessary; 2) prescribed by a physician who is a Participating Provider; and 3) provided under the Participating Provider's treatment plan. This plan includes:

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

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

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

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

For the purposes of this section, the term "**Autism Spectrum Disorder**" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the Diagnostic and Statistical Manual of Mental Disorders, also known as DSM-V-TR, current edition, text revision. This is published by the American psychiatric association 'This includes autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder.

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

We cover family planning services to help determine the number and spacing of children. These services include all methods of birth control approved by the FDA. As a Member, You pick a doctor who is located near You to receive the services You need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. You can do this without having to get Prior Authorization from Molina. (Molina pays the doctor or clinic for the family planning services You get.) Family planning services include:

- Health management and counseling to help You make informed choices
- Health management and counseling to help You understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Pregnancy testing and counseling
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Screening, testing and counseling of at-risk individuals for HIV, and referral for treatment

We are compliant with Health Resources and Services Administration (HRSA) guidelines and include all Food and Drug Administration (FDA) -approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services).

Contraceptives are provided for up to a six month supply. In addition, as noted in the Preventive Services for Adults and Seniors section of this document, there is no cost-sharing to You for covered contraceptives. Additionally, Molina does

not impose utilization review, prior authorization or step therapy requirement nor do We have other restrictions on coverage for covered contraceptives.

The contraceptive methods for women currently identified by the FDA include:

- sterilization surgery for women;
- surgical sterilization implant for women;
- implantable rod;
- IUD copper;
- IUD with progestin;
- shot/injection;
- oral contraceptives (combined pill);
- oral contraceptives (progestin only);
- oral contraceptives extended/continuous use;
- patch;
- vaginal contraceptive ring;
- diaphragm;
- sponge;
- cervical cap;
- female condom;
- spermicide;
- emergency contraception (Plan B/Plan B One Step/Next Choice); and
- emergency contraception (Ella).

Pregnancy Terminations

To the extent permitted by state and federal law, Molina Healthcare only covers pregnancy termination services in the following instances:

- If the Member's pregnancy is the result of an act of rape or incest;
- In the case where the Member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a Participating Provider, place the Member in danger of death unless a pregnancy termination is performed.

Pregnancy termination services are office-based procedures and do not require Prior Authorization.

If pregnancy termination services will be provided in an inpatient setting or outpatient hospital, Prior Authorization is required. Office Visit and Outpatient Surgery Cost Sharing will apply.

Keep in mind that some hospitals and providers may not provide pregnancy termination services.

Direct access to women's health care practitioners

A female covered person whose primary care practitioner is not a women's health care practitioner shall have direct and timely access to an in-network, participating women's health care practitioner for women's health care coverage, as defined at Subsection I of 13.10.21.7 NMAC.

Diabetes Services

We cover Medically Necessary care for Members with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage includes the medically accepted standard of medical care for diabetes and benefits for diabetes treatment. The coverage also includes Medically Necessary equipment, supplies, and prescriptive oral agents (i.e., drugs You take by mouth) for controlling blood sugar levels. This coverage will not be reduced or eliminated.

We also cover education regarding diabetes care management.

All treatment, equipment, and supplies for diabetes care and diabetes education and management are subject to applicable Cost Sharing.

When new or improved equipment, appliances, prescription drugs, insulin, or supplies for the treatment of diabetes are approved by the U.S. Food and Drug Administration, Molina will evaluate if changes or additions to formulary/coverage under this EOC are necessary. Please contact Molina's Customer Support Center toll-free at 1 (888) 295-7651 for up-to-date information.

Phenylketonuria (PKU) And Other Inborn Errors Of Metabolism

We cover testing and treatment of phenylketonuria (PKU). We also cover other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. The health care professional will consult with a 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)

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient Surgery

We cover outpatient surgery services provided by Participating Providers. Services must be provided in an outpatient or ambulatory surgery center or in a hospital operating room. Separate Cost Sharing may apply for professional services and Health Care Facility services.

Outpatient Procedures (other than surgery)

We cover some outpatient procedures other than surgery provided by Participating Providers. A licensed staff member must be required to monitor Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. These procedures include Medically Necessary endoscopic procedures. They also include the administration of injections and infusion therapy. Separate Cost Sharing may apply for professional services and Health Care Facility services for all outpatient procedures.

Specialized Imaging and Scanning Services

We cover specialized scanning services to include CT Scan, PET Scan, cardiac imaging and MRI by Participating Providers. Separate Cost Sharing may apply for professional services and facility services. Prior Authorization is required. Molina will help you select an appropriate facility.

Radiology Services (X-Rays)

We cover Medically Necessary x-ray and radiology services, other than specialized scanning services, when furnished by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

Chemotherapy and Other Provider-Administered Drugs

We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility Cost Sharing.

Laboratory Tests

We cover the following services when furnished by Participating Providers and Medically Necessary.; These services are subject to Cost Sharing. You must receive these services from Participating Providers, otherwise, the services are not covered. You will be 100% responsible for payment to non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

- Laboratory tests
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- Blood and blood plasma
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high risk pregnancy
- Alpha-Fetoprotein (AFP) screening

Mental/Behavioral Health

Outpatient Intensive Psychiatric Treatment program

We cover the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

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

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services except in the case of an Emergency or Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency or Urgent Care Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments to non-Participating Providers, and the payments will not apply to Your Deductible or Your Out-of-Pocket Maximum

Medical/Surgical Services

We cover the following inpatient services in a Participating Provider hospital. These services are generally and customarily provided by acute care general hospitals inside Our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialist physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to “Prescription Drugs and Medications” in this “What is Covered Under My Plan?” section)
- Biologicals, fluids and chemotherapy
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- 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, including Covered Services under the “Reconstructive Surgery” section and under the “Prosthetic and Orthotic Devices” section
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Chemotherapy and Other Provider-Administered Drugs

We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility Cost Sharing.

Maternity Care

Molina covers medical, surgical and hospital care during the term of pregnancy. This includes prenatal, intrapartum and perinatal care, upon delivery for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

We cover the following maternity care services related to labor and delivery:

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays need to be Authorized by Molina Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC) for the Cost Sharing that will apply to these services.
- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is shortened, then at least 3 home care visits will be provided. You and Your physician may agree that 1 or 2 visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory Tests Cost Sharing will apply to laboratory services).
- If You are a medically high-risk pregnant woman about to deliver a baby, we cover transportation, including air transport, to the nearest appropriate Health Care Facility when necessary to protect the life of the infant or mother.

Newborn and Adopted Children Coverage

We cover the newly born, adopted children, and children placed in foster care of the Subscriber or the Subscriber's Spouse. Coverage begins from the moment of the child's birth, adoption, or placement of foster care so long as the child is timely and properly enrolled in this Agreement.

Coverage of a Member's newly born natural, adopted children, or foster children includes coverage of injury or sickness and circumcision for newborn males. Coverage also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. When necessary to protect the life of the newborn infant, transportation (including air transport) to the nearest appropriate Health Care Facility also is covered.

Applicable Cost Sharing applies to these services.

MENTAL/BEHAVIORAL HEALTH

Inpatient Psychiatric Hospitalization

We cover inpatient hospital mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. This includes short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Involuntary inpatient mental health and behavioral health admissions do not require Prior Authorization. Involuntary inpatient mental health and behavioral services beyond 72 hours will be covered only if deemed Medically Necessary as determined by Your Provider in consultation with Molina's Medical Director.

"**Mental Disorders**" include the following conditions:

- Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa

Molina covers the screening, diagnosis and treatment of Autism Spectrum Disorder only as provided in this Agreement under 1) "Preventive Care for Children and Adolescents" in the "Preventive Services and the Affordable Care Act" section above, and 2) "Autism Spectrum Disorder" in the "Pediatric Services" section above.

SUBSTANCE USE DISORDER

Inpatient Detoxification

We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of its withdrawal symptoms. This includes room and board, Participating Provider physician services, drugs, dependency recovery services, education, and counseling.

Transitional Residential Recovery Services

We cover substance abuse treatment in a nonmedical transitional residential recovery setting approved in writing by Molina. These settings provide counseling and support services in a structured environment.

SKILLED NURSING FACILITY (60 DAYS PER CALENDAR YEAR)

We cover skilled nursing facility (SNF) services when Medically Necessary and referred by Your PCP. Covered SNF services include:

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

You must have Prior Authorization for these services before the service begins. Services must be billed by a Skilled Nursing Facility Participating Provider. You will continue to get care without interruption.

Hospice Care

If You are terminally ill, we cover these hospice services:

- Home hospice services
- A semi-private room in a hospice facility
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services for outpatient care
- Physician services
- Drugs
- Medical supplies and appliances
- Respite care for up to seven days per occurrence. Respite is short-term inpatient care provided to give relief to a person caring for You
- Counseling services for You and Your family
- Development of a care plan for You
- Short term inpatient care
- Pain control
- Symptom management
- Physical therapy, occupational therapy, and speech-language therapy. We provide these therapies for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

The hospice benefit is for people who are diagnosed with a terminal illness. Terminal illness means a life expectancy of 12 months or less. They can choose hospice care instead of the traditional services covered by this Agreement. Please contact Molina for further information.

Approved Clinical Trials

We cover routine patient care costs for qualifying Members. Qualifying Members are those participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You must:

- Be enrolled in this Agreement
- Be diagnosed with cancer or other life threatening disease or condition
- Be accepted into an approved clinical trial (as defined below)
- Be referred by a Molina doctor who is a Participating Provider

For a cancer clinical trial, You need not be diagnosed with cancer. You may participate if the approved clinical trial is undertaken for the purposes of the prevention or early detection of cancer.

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial. These trials are conducted in relation to the prevention, detection, or treatment of cancer. They may also be conducted for other life-threatening disease or condition. In addition:

- 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
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and Prior Authorization requirements that apply to routine and inpatient care for Members not in an approved clinical trial also apply to routine and inpatient care for Members in approved clinical trials. Contact Molina or Your PCP for further information.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Your routine patient costs. Such costs are associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this EOC based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered. They will not be covered if the approved clinical trial is for the investigation of that drug. They will also not be covered for medication that is typically provided free of charge to Members in the clinical trial.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service was not specifically related to an approved clinical trial. In other words, You will pay the Cost Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

Molina 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 You incur these costs while in an approved clinical trial. Costs excluded from coverage under this Agreement include:

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

Bariatric Surgery (limited to one per lifetime)

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

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

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

We will cover only one bariatric surgery for You during Your lifetime.

Reconstructive Surgery

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body. These abnormal structures may be caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. If a Participating Provider physician decides that it is necessary to improve function, or create a normal appearance, to the extent possible, the services will be covered.
- Following Medically Necessary removal of all or part of a breast, Molina covers reconstruction of the breast. Molina will also cover surgery and reconstruction of the other breast to produce a symmetrical appearance. Molina covers treatment of physical complications, including lymphedemas.

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services are not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC).

Reconstructive surgery exclusions

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 to improve appearance

Transplant Services

We cover transplants of organs, tissue, or bone marrow at participating facilities. Molina must authorize services for care to a transplant facility, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

After the authorization to a transplant facility, the following applies:

- If either the physician or the authorized Health Care Facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that decision is made.
- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor. Molina will provide services for an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You. This may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at 1 (888) 295-7651.

For covered transplant services, You will pay the Cost Sharing You would pay if the Covered Services were not related to transplant services. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC). Limited transplant-related travel services will be covered subject to Prior Authorization. Guidelines for transplant-related travel services are available by calling Our Customer Support Center toll-free at 1 (888) 295-7651.

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

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications when:

- They are ordered by a Participating Provider treating You and the prescription drug is listed in the Molina Drug Formulary or has been approved by Molina's Pharmacy Department
- They are ordered or given while You are in an emergency room or hospital
- They are given while You are in a skilled nursing facility and are ordered by a Participating Provider in connection with a Covered Service. The prescription drug or medication must be filled through a pharmacy that is in the Molina pharmacy network.
- The prescription drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

We cover prescription drugs and medications at a plan contracted retail pharmacy unless a prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education that cannot be provided by a retail pharmacy.

Please note, cost sharing for any prescription brand name drugs with an available and medically appropriate generic equivalent obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third party cost-sharing assistance, will not apply toward any Deductible, or the Annual Out-of-Pocket Maximum under Your Plan.

We cover:

- Tier-1: Preferred Generic Drugs
- Tier-2: Preferred Brand Drugs
- Tier-3: Non-Preferred Brand and Generic Drugs
- Tier-4: Brand and Generic Specialty Drugs
- Tier-5: Preventive Drugs

We cover drugs when they are on the Drug Formulary. We cover drugs when obtained through Molina's Participating Provider pharmacies within the Service Area. Non-formulary drugs may be covered only as provided in the "Access to Drugs Which Are Not Covered" section below.

Prescription drugs are covered outside the Service Area for Emergency Services only.
If You have trouble getting a prescription filled at the pharmacy, please call Our Customer Support Center toll-free at 1 (888) 560-4087 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629 or contact Us with the Telecommunications Relay Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 560-4087. You may view a list of pharmacies on Molina Healthcare's website MolinaMarketplace.com.

Molina Healthcare Drug Formulary (List of Drugs)

Molina Healthcare has a list of drugs that We will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community.

The group meets every 3 months to talk about the drugs that are in the Drug Formulary. They review new drugs and changes in health care, in order to find the most effective drugs for different conditions. Drugs are added to or removed from the Drug Formulary based on changes in medical practice and medical technology. They may also be added to the Drug Formulary when new drugs come on the market.

Some of the reasons Your drug may not be approved are:

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

Formulary generic drugs are those drugs listed in the Molina Drug Formulary that have the same ingredients as brand name drugs. To be FDA (government) approved, a generic drug must have the same active ingredient, strength, and dosage (formulation) as the brand name drug. Companies making a generic drug have to prove to the FDA that the drug works just as well and is as safe as the brand name drug.

Formulary brand name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina and Our pharmacy benefit manager.

You can look at Our Drug Formulary on Our Molina Healthcare website at MolinaMarketplace.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 560-4087, Monday through Friday, 8:00 a.m. through 5:00 p.m. ET. If You are deaf or hard of hearing, call toll-free 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

You can also ask Us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Cost Sharing for Prescription Drugs and Medications

The Cost Sharing for prescription drugs and medications is listed in the Summary of Benefits and Coverage (SBC). Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, is not subject to Cost Sharing. The amount You pay is the lesser of the Cost Sharing shown in the Summary of Benefits and Coverage (SBC) or the amount Molina has negotiated.

Prescription Drug Synchronization

We comply with 59A-46-53. Pharmacy benefits; prescription synchronization. (2015) . This means that You are allowed to fill or refill a prescription for less than a thirty-day supply of the prescription drug, and apply a prorated daily copayment or coinsurance for the fill or refill, if:

1. the prescribing practitioner or the pharmacist determines the fill or refill to be in the best interest of the enrollee;
2. You request or agree to receive less than a thirty-day supply of the prescription drug; and\
3. the reduced fill or refill is made for the purpose of synchronizing the enrollee's prescription drug fills.

Molina will not deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions. We will allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to Subsection A of this section.

Tier-1: Preferred Generic Drugs

Formulary drugs in this tier include preferred generic drugs. Specialty drugs are not included in this tier.

Preferred generic drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as "Tier-1" in the Molina Drug Formulary.

Tier-2 Preferred Brand Name Drugs

Formulary drugs in this tier include preferred brand drugs. Specialty drugs are not included in this tier.

Preferred brand drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as "Tier-2" in the Molina Drug Formulary. .

Tier-3 Non-Preferred Brand and Generic Drugs

Formulary drugs in this tier include non-preferred brand and generic drugs. Specialty drugs are not included in this tier. Non-preferred brand and generic drugs are those drugs listed in the Molina Drug Formulary that are designated as "Tier-3" due to lesser clinical effectiveness and cost differences. Generally, there are preferred and often less costly therapeutic alternatives at a lower tier.

Tier-4 Brand and Generic Specialty Drugs

Formulary drugs in this tier include both brand and generic specialty drugs, including biosimilars.
Specialty drugs are prescription legend drugs within the Molina Healthcare Drug Formulary that:

- Are only approved to treat limited patient populations, indications or conditions, including but not limited to growth hormone injections and drugs for treatment of infertility; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies; or
- A biosimilar, a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

Molina may require that Specialty drugs be obtained from a Participating Provider specialty pharmacy or facility for coverage. Our specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office.

We cover orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications. All orally administered cancer medications will be covered on the same basis and at no greater Cost Sharing than imposed for IV or injected cancer medication. Please check your Schedule of Benefits for applicable Cost Share for an orally administered anti-cancer medication. The maximum Cost Share for an orally administered anti-cancer medication is for up to a 30 day supply and is not subject to a Deductible.

Tier-5 Preventive Drugs

Formulary Preventive drugs are drugs listed in the Molina Drug Formulary that are considered to be used for preventive purposes, including all methods of birth control drugs or devices for women approved by the FDA, or if they are being prescribed primarily (1) to prevent the symptomatic onset of a condition in a person who has developed risk factors for a disease that has not yet become clinically apparent or (2) to prevent recurrence of a disease or condition from which the patient has recovered. A drug is not considered preventive if it is being prescribed to treat an existing, symptomatic illness, injury, or condition. Formulary Preventative drugs may include Generic or Brand Name drugs.

Opioid Analgesics Prescribed for Chronic Pain

If You are prescribed opioid analgesics for chronic pain, You must obtain a Prior Authorization prior to receiving opioid analgesics for chronic pain, except under the following circumstances:

- Opioid analgesics prescribed to a Member who is a hospice patient in a hospice care program;
- Opioid analgesics prescribed to a Member who has been diagnosed with a terminal condition, but is not a hospice patient in a hospice care program; or
- Opioid analgesics prescribed to a Member who has cancer or another condition

Access to Drugs That Are Not Covered

Molina has a process to allow You to request and gain access to clinically appropriate drugs that are not covered under Your product.

Molina Healthcare may cover specific non-formulary drugs when the prescriber documents in Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

If Your doctor prescribes a drug that is not listed on the Drug Formulary, Your doctor must submit a Prior Authorization request to Molina Healthcare's Pharmacy department.

- If You do not obtain a Prior Authorization from Molina, We will send a letter to You and Your doctor stating why the drug was denied. You may purchase the drug at the full cost charged by the pharmacy.
- If You obtain a Prior Authorization from Molina, We will contact Your doctor. You may purchase the drug at the Cost Sharing for Tier-3 for non-specialty drugs or Tier-4 for specialty drugs.

For substitution of a Formulary Generic Drug with a Non-Formulary Brand Drug, You may purchase the brand name drug at the following Cost Sharing:

- The Cost Sharing for Tier-3 for non-specialty drugs or Tier-4 for specialty drugs, plus
- The difference in cost between the formulary generic drug and brand name drug.

If You are taking a drug that is no longer on Our Drug Formulary, Your doctor can ask Us to keep covering it by sending Us a Prior Authorization request for the drug.
The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You**.**

There are two types of requests for clinically appropriate drugs that are not covered under Your product:

- Expedited Exception Request for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- Standard Exception Request.

You and/or Your Participating Provider will be notified of Our decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request. Note: if Molina fails to respond within 72 hours, the request is deemed to be approved.

If initial request is denied, You and/or Your Participating Provider may request an IRO review. You and/or Your Participating Provider will be notified of the IRO's decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

Over-the-Counter Preventive Drugs and Supplements

Over-the-counter drugs and supplements that are required by state and federal laws to be covered for preventive care are available at no charge when prescribed by a Participating Provider.

- Folic Acid for women planning or capable of pregnancy
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Iron Supplements for children age 6 to 12 months at increased risk for iron deficiency anemia
- Aspirin for adults for prevention of cardiovascular disease

Stop-Smoking Drugs

We cover drugs to help You stop smoking. You will have no Cost Sharing for stop smoking drugs. You can also learn more about Your stop-smoking options by visiting MolinaMarketplace.com.

Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a 3-month supply of stop-smoking medication.

Mail Order Availability of Formulary Prescription Drugs

Molina offers You a mail order Formulary Prescription drug option. Formulary Prescription drugs can be mailed to You within 10 days from order request and approval. Cost Sharing for up to a 90-day supply is two times Your appropriate Copayment or Coinsurance Cost Share based on Your drug tier for one month.

You may request mail order service in the following ways:

- You can order online. Visit MolinaMarketplace.com and select the mail order option. Then follow the prompts.
- You can call the FastStart® toll-free number at 1 (800) 875-0867. Provide Your Molina Marketplace Member number (found on Your ID card), Your prescription name(s), Your doctor's name and phone number, and Your mailing address.
- You can mail a mail-order request form. Visit MolinaMarketplace.com and select the mail order form option. Complete and mail the form to the address on the form along with Your payment. You can give Your doctor's office the toll-free FastStart® physician number 1 (800) 378-5697 and ask Your doctor to call, fax, or electronically prescribe Your prescription. To speed up the process, Your doctor will need Your Molina Marketplace Member number (found on Your ID card), Your date of birth, and Your mailing address.

Cancer Drug Therapy

As required by state law, drugs for cancer therapy and reasonable costs for administering them are covered. These drugs are covered regardless of whether the federal FDA has approved the cancer drug to be used for the type of tumor for which the drugs are being used. Reasonable costs means items and services delivered to the Member that are consistent with and typically covered by Molina for coverage for a Member who is not enrolled in cancer drug therapy.

Diabetic Supplies

Diabetic supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, blood glucose test strips and urine test strips are covered supplies. Select pen delivery systems for the administration of insulin are also covered.

Day Supply Limit

The prescribing Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of an item that constitutes a Medically Necessary 30-day supply for You. Upon payment of the Cost Sharing specified in this "Prescription Drug Coverage" section, You will receive the supply prescribed up to a 30-day supply in a 30-day period. Quantities that exceed the day supply limit are not covered unless Prior Authorization is obtained.

Off Label Prescription Drugs

Molina Healthcare will not limit or exclude coverage for a drug approved by the FDA on the basis that the drug has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided that:

- The drug has been recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider."

- Alternatively, as provided for an approved clinical trial for cancer, pursuant to Section 59A-22-43 NMSA and this EOC.

Coverage of a drug for off label uses as permitted by this EOC includes Medically Necessary services associated with the administration of the drug, if such services would not be otherwise excluded from coverage under this EOC.

Coverage of a drug for off label uses includes coverage for prescription contraceptive drugs or devices, pursuant to Sections 59A-22-42 and 59A-46-44 NMSA 1978.

Nothing in this section requires Molina to:

- Cover any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed.
- Cover Experimental or Investigational drugs not approved for any indication by the FDA.
- Provide reimbursement for or coverage of any drug not included on Molina's drug formulary; unless an exception request has been granted for the drug in accordance with the process outlined in the Section entitled "Access to Drugs Which are Not Covered."

ANCILLARY SERVICES

Durable Medical Equipment

If You need Durable Medical Equipment, Molina Healthcare will rent or purchase the equipment for You. Prior Authorization (approval) from Molina Healthcare is required for Durable Medical Equipment. The Durable Medical Equipment must be provided through a vendor that is contracted with Molina Healthcare. We cover reasonable repairs, maintenance, delivery, and related supplies for Durable Medical Equipment. You may be responsible for repairs to Durable Medical Equipment if they are due to misuse or loss.
Covered Durable Medical Equipment includes (but is not limited to):

- Oxygen and oxygen equipment
- Apnea monitors
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Colostomy supplies (limited to pouches, face plates, belts, irrigation catheters, and skin barriers)

In addition, we cover the following Durable Medical Equipment and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Podiatric devices to prevent or treat diabetes related foot problems
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but we do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are 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 Your medical needs

- You receive the device from the provider or vendor that Molina Healthcare selects

When we do cover a prosthetic and orthotic device, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a prosthetic or orthotic device. If we cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, Osseo integrated hearing devices, and joints if these devices are implanted during a surgery that is otherwise covered by Us.

For internally implanted devices, please refer to the "Inpatient Hospital Services" or "Outpatient Hospital/Facility Services" sections (as applicable) of the Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC) to see the Cost Sharing applicable to these devices.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months when required to hold a prosthesis.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Prostheses used to replace a missing part (such as a hand, arm, or leg) that is needed to alleviate or correct illness, injury, or congenital defects, including braces (not orthodontic braces), limited to medically appropriate equipment and subject to Prior Authorization. Repair or replacement of such prostheses is a Covered Service only when Medically Necessary and subject to Prior Authorization.

For external devices, Durable Medical Equipment Cost Sharing will apply.

Home Healthcare (100 visits per calendar year)

We cover these home health care services – i.e., health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness – when such services are Medically Necessary, referred by Your PCP, and approved by Molina Healthcare:

- Part-time skilled nursing services
- Nurse visits
- In-home medical care services
- Physical therapy, occupational therapy, or speech therapy
- Medical social services
- Home health aide services
- Medical supplies

- Necessary medical appliances

The following home health care 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)

You must have Prior Authorization for all home health services before obtaining services. Services must be billed by a Home Health Care Participating Provider agency.
Please refer to the "Exclusions" section of this EOC for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation

We cover emergency medical transportation (ground and air ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary. We also cover emergency transportation from one medical facility to another when ordered by the treating physician and when medically necessary. These services are covered only when other types of transportation would put your health or safety at risk. Covered emergency medical transportation services will be provided at the cost share identified within the Summary of Benefits and Coverage (SBC), up to the lesser of Molina's Allowed Amount for such services.

Non-Emergency Medical Transportation

We cover non-routine, non-Emergency Medically Necessary ground transportation, when Molina determines such transportation is needed within Our Service Area to transfer You from one medical facility to another. Examples of this are from one hospital to another hospital, from a hospital to a skilled nursing facility or hospice. Non-Emergency medical transportation is provided by wheelchair lift equipped vehicle, litter/stretcher van or non-Emergency ambulance (both advanced life support and basic life support). When non-Emergency medical transportation is needed, Molina will arrange for the transportation to be provided by one of our Participating Provider transportation vendors. Please note, this is not a service for which you can self-refer and any services not arranged by Molina will not be covered.

OTHER SERVICES

Dialysis Services

We cover acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina Healthcare.

Prior Authorization is not required. However, a onetime notification is requested. Please notify Molina before services are rendered by calling 1(888) 295-7651

Chiropractic Services

We cover chiropractic diagnostic and treatment services when furnished by licensed Participating Providers and appropriate for the treatment of Your conditions. Coverage for chiropractic care is limited to 20 visits in each calendar year, unless for habilitative or rehabilitative purposes. Cost Sharing applicable to outpatient services will apply.

Acupuncture Services

We cover acupuncture diagnostic and treatment services when provided for Habilitative and Rehabilitative services only, when furnished by licensed Participating Providers and appropriate for the treatment of Your conditions. Coverage includes complimentary acupuncture services without Prior Authorization for specified medical conditions. Coverage does not include any maintenance therapy Cost Sharing applicable to outpatient services will apply.

COVERED SERVICES FURNISHED WHILE TRAVELING OUTSIDE THE SERVICE AREA (INCLUDING THE UNITED STATES)

Your Covered Services include Urgent Care Services and Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United States. If You require Urgent Care Services or Emergency Services while traveling outside the United States, please use that country's or territory's emergency telephone number or go to the nearest emergency room.

If You receive health care services while traveling outside the United States or outside the Service Area, You will be required to pay the Non-Participating Provider's charges at the time You obtain those services. You may submit a claim for reimbursement to Molina Healthcare for charges that You paid for Covered Services furnished to You by the Non-Participating Provider. Members are responsible for ensuring that claims and/or records of such services are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. Medical records of treatment/service may also be required for proper reimbursement from Molina.

Your claims for reimbursement for Covered Services should be submitted as follows:

Molina Healthcare
P.O. Box 22801
Long Beach, CA 90801

Claims for reimbursement for Covered Services while You are traveling outside the United States must be verified by Molina Healthcare before payment can be made. Molina will calculate the allowed amount that will be covered for Urgent Care Services and Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws. You will not be entitled to reimbursement for charges for health care services or treatment that are excluded from coverage under this EOC, specifically those identified in "Services Provided Outside the United States (or Service Area)" in the "Exclusions" section of this EOC.

Hearing Services

We do not cover hearing aids (other than internally implanted devices and hearing aids for Dependents up to age 21 as described in the "Pediatric Services" section).

We do cover the following:

- Routine hearing screenings that are Preventive Care Services: no charge

EXCLUSIONS

What is Excluded from Coverage Under My Plan?

This "Exclusions" section lists specific items and services excluded from coverage under this EOC. These exclusions apply to all services that would otherwise be covered under this EOC regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Certain Exams and Services

Physical exams and other services 1) required for obtaining or maintaining employment or participation in employee programs, 2) required for insurance or licensing, or 3) on court order or required for parole or probation. This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary.

Cosmetic Services

Services that are intended primarily to change or maintain Your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "What is Covered Under My Plan?" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial Care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

Dental and Orthodontic Services

Dental and orthodontic services such as x-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to services covered under "Dental and Orthodontic Services" in the "What is Covered Under My Plan?" section.

Dietician

A service of a dietician is not a covered benefit. This exclusion does not apply to services under "Hospice Care" or for Covered Services described in the section titled, "Phenylketonuria (PKU) and Other Inborn Errors of Metabolism".

Disposable Supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, under pads, and other incontinence supplies.

This exclusion does not apply to disposable supplies that are listed as covered in the "What is Covered Under My Plan?" section.

Erectile Dysfunction Drugs
Coverage of erectile dysfunction drugs unless required by state law.

Experimental or Investigational Services
Any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

This exclusion does not apply to any of the following:

- Services covered under “Approved Clinical Trials” in the “What is Covered Under My Plan?” section

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

Gene Therapy

"Most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.

Hair Loss or Growth Treatment
We do not cover Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Infertility Services
Molina Healthcare does not cover infertility services except as specifically provided in “Services of Physicians and Other Practitioners” in “What is Covered Under My Plan?” section. These are examples of the services and costs that Molina does not cover:

- Any services related to artificial insemination and any cost in connection with the collection, preparation, storage of sperm for artificial insemination, including donor fees
- Any services related to 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)
- Reversal of voluntary sterilization surgery
- Surrogate parenting
- Infertility medications, including oral infertility drugs

Intermediate Care
Care in a licensed intermediate care facility. This exclusion does not apply to services covered under “Durable Medical Equipment,” “Home Health Care,” and “Hospice Care” in the “What is Covered Under My Plan?” section.

Items and Services That are Not Health Care Items and Services

Molina Healthcare does not cover services that are not health care services. example Examples of these types of services are:

- 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 You how to read, whether or not You 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

Items and Services to Correct Refractive Defects of the Eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section.

Massage Therapy and Alternative Treatments

We do not cover alternative treatments including, but not limited to, massage therapy, aromatherapy, or hypnotherapy.

Oral Nutrition

Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- 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 EOC.

Private Duty Nursing Services

We do not cover private duty nursing services.

Residential Care

Care in a facility where You stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive

psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery services covered under the "Substance Abuse Disorder Services" section.

Routine Foot Care Items and Services

Routine foot care items and services which are not Medically Necessary (for example, Medically Necessary for the treatment of diabetes)

Services Not Approved by the Federal Food and Drug Administration

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. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan" section.

Please refer to the "Independent Medical Review for Denials of Experimental/Investigational Therapies" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People

We do not cover services performed by people who do not require licenses or certificates by the state to provide health care services, except as otherwise provided in this EOC.

Services Related to a Non-Covered Service

When a Service is not covered, all services related to the non-Covered Service are excluded; except for services, Molina Healthcare would otherwise cover to treat complications of the non-Covered Service. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service. For example, if You have a non-covered bariatric or cosmetic surgery, Molina Healthcare would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina Healthcare would cover any services that Molina Healthcare would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, 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

Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina's travel and lodging guidelines. Molina Healthcare's travel and lodging guidelines are available from Our Customer Support Center by calling toll free at 1 (888) 295-7651 or call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 659-8331 or dial 711 for the Telecommunications Service.

Out-of-network services

In the event medically necessary covered services are not reasonably available through Participating Providers, You may request a referral to a Provider who is not contracted with Molina. Molina will, in consultation with Your Provider, and if medically necessary, provide a referral for You to a Provider who is not in the Molina network. Molina will provide this referral when there is no other Provider who can provide comparable medically necessary treatment. Molina will reimburse the non-Participating provider at the usual, customary and reasonable rate, or at an agreed upon rate. If Molina denies Your request for treatment by a non-Participating provider, the request will be reviewed by a specialist similar to the type of specialist to whom the referral is requested.

No Prior Authorization is required for out-of-network emergency care. Additionally, out-of-network emergency care is provided to You at no more than the Emergency Services cost-sharing shown in Your Summary of Benefits and Coverage (SBC). A determination regarding whether or not out-of-network emergency care was medically appropriate will be determined by the standards set forth in New Mexico Administrative Code 13.10.21.8(4).

Services Provided Outside the United States (or Service Area)

Any services and supplies provided to a Member outside the United States if 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, specialist care, and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area unless they are Urgent Care Services or Emergency Services furnished to a Member while traveling.

When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered.

COORDINATION OF BENEFITS

This Coordination of Benefits ("**COB**") provision applies when a person has health care coverage under more than one Plan. For purposes of this COB provision, 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 do not exceed 100% of the total Allowable Expense.

Definitions (applicable to this COB provision)

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 non-group 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; 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) or (2) 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:

- "**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.

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. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

"**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 Member is not an Allowable Expense.

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

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.

1. If a person is covered by 2 or more Plans that compute their benefit payments based on usual and customary fees, 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.

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

3. 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 from 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.

4. The amount of any benefit reduction by the Primary Plan because a Member 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.

"**Closed Panel Plan**" is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers which 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.

"**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 Benefit Determination Rules-

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.

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

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

B. 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. 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.

However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that 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 not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a

retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

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

Effect On The Benefits Of This Plan

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

If a Member 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. We 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. If You do not provide Us the information we need to apply these rules and determine the benefits payable, Your claim for benefits will be denied.

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. We 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.

Right of Recovery

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

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

Third-party liability

You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, if You are made whole for all other damages resulting from the wrongful act or omission before Molina Healthcare is entitled to reimbursement, then You shall:

- Reimburse Molina Healthcare for the reasonable cost of services paid by Molina Healthcare to the extent permitted by New Mexico law immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Molina Healthcare's effectuation of its lien rights for the reasonable value of services provided by Molina Healthcare to the extent permitted under New Mexico law. Molina Healthcare's lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

Molina Healthcare shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and You shall cooperate to fully and completely assist in protecting the rights of Molina Healthcare including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina Healthcare shall not furnish benefits under this Agreement that duplicate the benefits to which You are entitled under any applicable workers' compensation law. You are responsible for taking whatever action is 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 Healthcare's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises

between You and the Workers' Compensation carrier, as to Your ability to collect under workers' compensation laws, Molina Healthcare will provide the benefits described in this Agreement until resolution of the dispute.

If Molina Healthcare provides benefits which duplicate the benefits You are entitled to under workers' compensation law, Molina Healthcare shall be entitled to reimbursement for the reasonable cost of such benefits.

RENEWAL AND TERMINATION

How Does my Molina Healthcare Coverage Renew?

Coverage shall be renewed on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. Renewal is subject to Molina Healthcare's right to amend this EOC. You must follow the procedures required by the Marketplace to redetermine Your eligibility for enrollment every year during the Marketplace's annual open enrollment period.

Changes in Premiums, Deductibles, Copayments and Covered Services:

Any change to this Agreement, including, but not limited to, changes in Premiums, or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina. The Marketplace determines your eligibility and advance premium tax credit.

When Will My Molina Healthcare Membership End? (Termination of Covered Services)

The termination date of Your coverage is the first day You are not covered with Molina Healthcare (for example, if Your termination date is July 1, 2018, Your last minute of coverage was at 11:59 p.m. on June 30, 2018). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina Healthcare, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or intentional misrepresentation of material fact in the use of services or facilities, Molina Healthcare will return to You within 30 days the amount of Premiums paid to Molina Healthcare which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due Molina Healthcare.

Your membership with Molina Healthcare will terminate if You:

- **Cancel Your Coverage Within 10 Days**: You have 10 calendar days to examine this EOC. You may cancel Your coverage within 10 days of Your signing this Agreement and Molina Healthcare will refund Your premium. If Covered Services are received by any Member during this 10-day examination period, then the Subscriber must pay the full cost of those Covered Services if his or her premium has been returned.

- **No Longer Meet Eligibility Requirements:** You no longer meet the dependent age requirement or other eligibility requirements for coverage under this Agreement as required by Molina Healthcare or the Marketplace. You no longer live in New Mexico and live or work in the county in which you applied for coverage in Molina Healthcare's Service Area for this Agreement. The Marketplace will send You notice of any eligibility determination. Molina Healthcare will send You notice when it learns You have moved out of the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.

    - **For Non-Age-Related Loss of Eligibility,** Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.

    - **For a Dependent Child Reaching the Limiting Age of 26,** Coverage under this Agreement, for a Dependent child, will terminate at 11:59 p.m. on the last day of the calendar year in which the Dependent child reaches the limiting age of 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)".

    - **For a Member with Child-Only Coverage Reaching the Limiting Age,** that Member's Child-Only Coverage under this Agreement, will terminate at 11:59 p.m. on the last day of the calendar year in which the Member reaches the limiting age of 21. When Child-Only Coverage under this Agreement terminates because the Member has reached age 21, the Member be eligible to enroll in other products offered by Molina through the Marketplace.

- **Request Disenrollment:** You decide to end Your membership and disenroll from Molina Healthcare by notifying Molina Healthcare and/or the Marketplace. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. Molina Healthcare may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.

- **Have Child-Only Coverage**: Child-Only Coverage under this Agreement, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches age 21. When Child-Only Coverage under this Agreement terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Health Benefit Exchange.

- **Change the Marketplace Health Plans**: You decide to change from Molina Healthcare to another health plan offered through the Marketplace (i) if You timely cancel Your coverage under this EOC within 10 calendar days of Your signing it, (ii) during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with **t**he Marketplace's special enrollment procedures, or (iii) when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina Healthcare, in which case a notice of termination will be sent Your membership will end at 11:59 p.m. on the seventh day from the date the notice of termination is mailed. Some examples include:

    - Misrepresenting eligibility information.
    - Presenting an invalid prescription or physician order.

- Misusing a Molina Healthcare Member ID Card (or letting someone else use it).

After Your first 24 months of coverage, Molina Healthcare may not terminate Your coverage due to any intentional omissions, misrepresentations or inaccuracies in Your application form.

If Molina Healthcare terminates Your membership for cause, You may not be allowed to enroll with Us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

- **Discontinuation:** If Molina Healthcare ceases to provide or arrange for the provision of health benefits for new or existing health care service plan contracts, in which case Molina Healthcare will provide You with written notice at least 180 days prior to discontinuation of those contracts.

- **Withdrawal of Product:** Molina Healthcare withdraws this product from the market, in which case Molina Healthcare will provide You with written notice at least 90 days before the termination date.

- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina Healthcare may terminate Your coverage as further described below.

Your coverage under certain Covered Services will terminate if Your eligibility for such benefits end. If only certain Covered Services and Coverage end because a Member attains a certain age, then coverage of those benefits under this EOC will end at 11:59 p.m. on the last day of the calendar year in which the Member has reached the limiting age, without affecting that Member's coverage under the remainder of this EOC.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums

Your Premium payment obligations are as follows:

- Your Premium payment for the upcoming coverage month is due no later than the first day of that month. This is the "**Due Date.**" Molina Healthcare will send You a bill in advance of the Due Date for the upcoming coverage month. If Molina Healthcare does not receive the full Premium payment due on or before the Due Date, Molina Healthcare will send a notice of non-receipt of Premium payment and cancellation of coverage (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:

- A statement that Molina Healthcare has not received full Premium payment and that we will terminate this Agreement for nonpayment if we do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
- The amount of Premiums due.
- The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if we do not receive the required Premiums.

If You have received a Late Notice that Your coverage is being terminated or not renewed due to failure to pay Your Premium, Molina Healthcare will give a:

- 31-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit. Molina will process payment for Covered Services received during the grace period. You will be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period; or

- Three month grace period to pay the full Premium payment due if You receive advance payment of the premium tax credit. Molina will hold payment for Covered Services received after the first month of the grace period until We receive the delinquent Premiums. If Premiums are not received by the end of the three-month grace period, You will be responsible for payment of the Covered Services received during the second and third months.

During the grace period applicable to You, You can avoid termination or nonrenewal of this Agreement by paying the full Premium payment You owe to Molina Healthcare. If You do not pay the full Premium payment by the end of the grace period, this Agreement will be terminated. You will still be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period if You receive advance payment of the premium tax credit.

Termination or nonrenewal of this Agreement for non-payment will be effective:

- The last day of the grace period if You do not receive advance payment of the premium tax credit; or,
- The last day of the first month of the grace period if You receive advance payment of the premium tax credit

- Reinstatement After Termination If permitted by the Marketplace, We will allow reinstatement of Your Agreement (without a break in coverage) provided the reinstatement is a correction of an erroneous termination or cancellation action.

Re-enrollment After Termination for Non-Payment
If You are terminated for non-payment of premium and wish to re-enroll with Molina (during Open Enrollment or a Special Enrollment Period) in the following plan year, We may require that You pay any past due premium payments, plus Your first month's premium payment in full, before We will accept Your enrollment with Us.

Termination Notice: Upon termination of this Agreement, Molina Healthcare will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended.

YOUR RIGHTS AND RESPONSIBILITIES

What are My Rights and Responsibilities as a Molina Healthcare Member?

These rights and responsibilities are posted on the Molina Healthcare web site: MolinaMarketplace.com.

YOUR RIGHTS

You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina Healthcare.
- Get information about Molina Healthcare and Our products, Participating Providers, appeals procedures, services, policies and procedures.
- Available and accessible services when covered under this EOC and Medically Necessary, including Urgent Care Services and Emergency Services 24 hours a day, 7 days a week and for other Covered Services as defined by this EOC.
- Choose Your Primary Care Doctor (i.e., Your main doctor) from Molina Healthcare's list of Participating Providers and to refuse care of specific health care professionals.
- Receive from Your treating provider's information about Your health in terms You can understand.

- Be told by Your treating providers about all treatment options and risks regardless of cost or benefit coverage if You have an illness.
- Have all Your questions about Your health answered by Your treating providers.
- All rights under law, rule or regulation as patient in a licensed Health Care Facility, including the right to refuse medication and treatment after having the consequences explained to You by a provider in a language that You can understand and other rights as a patient.
- Privacy of Your medical and financial records maintained by Molina Healthcare and its Participating Providers, in accordance with applicable state and federal law.
- Complain about Molina Healthcare or Your care from Participating Providers. You can call, fax, e-mail, or write to Molina Healthcare's Customer Support Center.
- Complain or appeal Molina Healthcare's decisions to Molina or to the Superintendent of Insurance, and to receive an answer to those complaints in accordance with law.
- Prompt notification, as required by applicable law, of termination or changes in benefits, services, or Participating Providers.
- Request and receive information about any financial arrangements or provisions between Molina Healthcare and its Participating Providers that may restrict treatment options or limit the services offered to Members.
- Adequate access to qualified health professionals for the provision of Covered Services near where You live in New Mexico and live or work in the county in which you applied for coverage in Molina Healthcare's service area.
- Detailed information about coverage, maximum benefits, and exclusions of specific services, including restricted prescription benefits, and all requirements to obtain Prior Authorization for services.
- Affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a Non-Participating Provider (care provided by a Non-Participating Provider is not covered unless expressly stated in this EOC), and an explanation of Your financial responsibility when services are provided by a Non-Participating Provider, or provided without required Prior Authorization.
- A complete explanation of why Molina Healthcare has denied coverage for certain services, an opportunity to appeal Molina's decision, the right to a secondary appeal, and the right to request the Superintendent's assistance.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with applicable state laws.
- Get a copy of Molina Healthcare's list of approved drugs on the Drug Formulary upon request.
- Not to be treated poorly by Molina Healthcare or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.

Your Responsibilities

You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call Molina toll-free at 1 (888) 295-7651.
- Give to Your doctor, provider, or Molina Healthcare information that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed upon with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina Healthcare card when getting medical care. Do not give Your card to others. Let Molina Healthcare know about any fraud or wrong doing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals, as You are able.

Be Active In Your Healthcare

Plan Ahead

- Schedule Your appointments at a good time for You
- Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long
- Keep a list of questions You want to ask Your doctor
- Refill Your prescription before You run out of medicine

Make the Most of Doctor Visits

- Ask Your doctor questions
- Ask about possible side effects of any medication prescribed
- Tell Your doctor if You are drinking any teas or taking herbs. Also tell Your doctor about any vitamins or over–the-counter medications You are using

Visiting Your Doctor When You are Sick

- Try to give Your doctor as much information as You can.
- Are You getting worse or are Your symptoms staying about the same?
- Have You taken anything?

If You would like more information, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 295-7651, Monday through Friday, between 8:00 a.m. and 5:00 p.m. MT.

MOLINA HEALTHCARE SERVICES

Molina Healthcare is Always Improving Services

Molina Healthcare makes every effort to improve the quality of health care services provided to You. Molina Healthcare's formal process to make this happen is called the "Quality Improvement Process". Molina Healthcare does many studies through the year. If we find areas for improvement, we take steps that will result in higher quality care and service.

If You would like to learn more about what we are doing to improve, please call Molina Healthcare toll-free at 1 (888) 665-4621 for more information.

Member Participation Committee

We want to hear what You think about Molina Healthcare. Molina Healthcare has formed the Member Participation Committee to hear Your concerns.

The Committee is a group of people just like You that meets once every three (3) months and tells Us how to improve. The Committee can review health plan information and make suggestions to Molina Healthcare's Board of Directors. If You want 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 You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 659-8331 or dial 711 for the Telecommunications Service. Join Our Member Participation Committee today!

Your Healthcare Privacy

Your privacy is important to Us. We respect and protect Your privacy. Please read Our Notice of Privacy Practices.

New Technology

Molina Healthcare is always looking for ways to take better care of Our Members. That is why Molina Healthcare has a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

Our Medical Directors find new medical procedures, treatment, drugs, and devices when they become available. They present research information to the Utilization Management Committee where physicians review the technology. Then they suggest whether it can be added as a new treatment for Molina Healthcare Members.

For more information on new technology, please call Molina Healthcare's Customer Support Center.

What Do I Have to Pay For?

Please refer to the "Molina Healthcare of New Mexico, Inc. Summary of Benefits and Coverage (SBC)" for Your Cost Sharing responsibilities for Covered Services.

Note that You may be liable to pay for the full price of medical services when:

- You ask for and get medical services that are not covered, such as cosmetic surgery
- Except in the case of Emergency Care Services or Urgent Care Services, You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Your PCP or Molina Healthcare.

If Molina Healthcare fails to pay a Participating Provider for giving You Covered Services, You are not responsible for paying the provider for any amounts owed by Us. This is not true for providers who are not contracted with Molina Healthcare. For information on how to file a grievance if You receive a bill, please see below.

What if I have paid a medical bill or prescription?

(Reimbursement Provisions)

With the exception of any required Cost Sharing amounts (such as a Deductible, Copayment or Coinsurance), if You have paid for a Covered Service or prescription drug that was approved or does not require approval, Molina Healthcare will pay You back. You must submit Your claim for reimbursement within 12 months from the date you made the payment. You will need to mail or fax Us a copy of the bill from the doctor, hospital, or pharmacy and a copy of Your receipt. You should also include the name of the Member for whom you are submitting the claim and Your policy number.

If the bill is for a prescription drug, You will need to include a copy of the prescription drug label. Mail this information to Molina's Customer Support Center at:

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

After we receive Your request for reimbursement, we will respond to You within 30 days. If Your claim is accepted, we will mail You a check. If your claim is denied, we will send You a letter telling You why. If You do not agree with this, You may file an appeal by calling Molina Healthcare toll-free at 1 (888) 295-7651, Monday through Friday, 8:00 a.m. to 5:00 p.m. MT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

How Does Molina Healthcare Pay for My Care?

Molina Healthcare contracts with providers in many ways. Some Molina Healthcare Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina Healthcare does not provide financial incentives for utilization management decisions that could result in authorization denials or under-utilization. For more information about how providers are paid, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 295-7651, Monday through Friday, 8:00 a.m. to 5:00 p.m. MT. You may also call Your provider's office or Your provider's medical group for this information.

INTERPRETER SERVICES

Do You speak a language other than English?

Many people do not speak English or are not comfortable speaking English. Please tell Your doctor's office or call Molina Healthcare if You prefer to speak a language other than English. Molina Healthcare can help You find a doctor that speaks Your language or have an interpreter help You.

Molina Healthcare offers interpreter services to help You with:

- Making an appointment
- Talking with Your doctor or nurse
- Getting Emergency care in a timely manner
- Filing a complaint or grievance
- Getting health management services
- Getting information from the pharmacist about how to take Your medicine (drugs)

Tell Your doctor or anyone who works in his or her office if You need an interpreter. You may also ask for any of the documents that Molina Healthcare sends You in Your preferred written language. Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Molina Healthcare's Customer Support Center at 1 (888) 295-7651.

Cultural and Linguistic Services

Molina Healthcare can help You talk with Your doctor about Your cultural needs. We can help You find doctors who understand Your cultural background, social support services and help with language needs. Please call Molina Healthcare's Customer Support Center at 1 (888) 295-7651.

Language Assistance

Molina Healthcare will provide oral language services that include answering questions in any applicable non-English language and providing assistance with filing grievances and appeals (including external review) in any applicable non-

English language. You can request that any notice from Molina Healthcare be provided in any applicable non-English language. With respect to any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language as determined by the Department of Health and Human Services (HHS).

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. We will provide You a written copy of Our grievance and appeal process upon request. We will never retaliate against a Member in any way for filing a grievance or appeal. For the purposes of this section, any reference to "You", "Your" or "Member" also refers to a representative or health care provider designated by You to act on Your behalf, unless otherwise noted.

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 Molina. You will be provided with detailed information and complaint forms by Us at each step. In addition, You can review the complete New Mexico regulations that control the process on the Managed Health Care Bureau page found under the Department's 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 Healthcare of New Mexico, Inc. at: 1 (888) 295-7651or from the OSI by calling 1-505-827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

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

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

Review of an Adverse Determination

How does Prior Authorization for a health care service work?

When Molina receives a request for Prior Authorization of 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, We determine whether the requested service is a Covered Service under the terms of your Agreement. For example, if Your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

Medical Necessity: Next, if Molina finds that the requested service is a Covered Service under Your Agreement, Molina determines, in consultation with a physician, whether a requested service is Medically Necessary. The consulting physician determines Medical Necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by Molina. For example, if a person has a crippling hand injury that could be corrected by plastic surgery and that person is also requesting that an insurer pay for cosmetic plastic surgery to give them a more attractive nose, the insurer might certify the first request to repair the hand and deny the second, because it is not medically necessary.

Molina might also deny a Prior Authorization request if the service You are requesting is not a Covered Service. For example, if a policy does not pay for experimental procedures, and the service being requested is classified as experimental, the insurer may deny a request for authorization. Molina might also deny a Prior Authorization request if a procedure that Your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If Molina determines that it will not provide an Authorization for Your request for services, You may still go forward with the treatment or procedure. However, You will be responsible for paying the provider yourself for the services.

How long does initial Authorization take?

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

What if I need services in a hurry?

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

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

If You are dissatisfied with Molina's initial expedited decision in an urgent care situation, you may then request an **expedited review** of Molina's decision by both Molina and an external reviewer called an Independent Review

Organization (IRO). When an expedited review is requested, We must review Our prior decision and respond to Your request within 72 hours. If You request that an IRO perform an expedited review simultaneously with Our review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records. If You are still dissatisfied after the IRO completes its review, You may request that the Superintendent review Your request. This review will be completed within 72 hours after Your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If You are facing an Emergency, You should seek medical care immediately and then notify Us as soon as possible. We will guide You through the claims process once the Emergency has passed.

When will I be notified that my initial request has been either Authorized or denied?

If the initial request is Authorized, Molina must notify You and Your provider within 1 working day after the decision, unless an urgent matter requires a quicker notice. If Molina denies the Authorization request, We must notify You and Your provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If Your initial request for services is denied or You are dissatisfied with the way We handle an administrative matter, You will receive a detailed written description of the grievance procedures from Us as well as forms and detailed instructions for requesting a review. You must submit the request for review in writing, but assistance is available. Molina provides representatives who have been trained to assist You with the process of requesting a review. This person can help You to complete the necessary forms and with gathering information that You need to submit Your request. For assistance, contact Our Customer Support Center at:

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

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

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by You as the patient, Your provider, or someone that You select to act on Your behalf. The patient may be the Subscriber or a Dependent who receives coverage through the Subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review

If You are dissatisfied with the initial decision by Us, You have the right to request that Our decision be reviewed by Our medical director. The medical director may make a decision based on the terms of this Agreement, may choose to contact a specialist or the provider who has requested the service on Your behalf, or may rely on Molina's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify Molina that You wish to request an internal review within **180 days** after the date You are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

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

How long does a first level internal review take?

Expedited review. If a review request involves an urgent care situation, Molina 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. Molina must complete both the medical director's review and (if You then request it) Our internal panel review within **30 days** after receipt of Your pre-service request for review or within 60 days if You have already received the service.. The medical director's review generally takes only a few days.

The medical director denied my request - now what?

If You remain dissatisfied after the medical director's review, You may either request a review by a panel that is selected by Molina or You may skip this step and ask that Your request be reviewed by an IRO that is appointed by the Superintendent.

- If You ask to have Your request reviewed by Our panel, then You have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with You or on Your behalf. You may submit information that You want the panel to consider, and ask questions of the panel members. Your medical provider may also address the panel or send a written statement.

- If You decide to skip the panel review, You will have the opportunity to submit Your information for review by the IRO, but You will not be able to appear in person or by telephone. OSI can assist You in getting Your information to the IRO.

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

How long do I have to make my decision?

If You wish to have Your request reviewed by Molina's panel, You must inform Us within **5 days** after You receive the medical director's decision. If You wish to skip Molina'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 We provide a panel to review Our decision, We will schedule a hearing with a group of medical and other professionals to review the request. If Your request was denied because We felt the requested services were not Medically Necessary, or were Experimental or Investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

Molina will contact You with information about the panel's hearing date so that You may arrange to attend in person or by telephone, or arrange to have someone attend with You or on Your behalf. You may review all of the information that We 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, and may address the panel or send a written statement.

Molina's internal panel must complete its review within **30 days** following Your original request for an internal review or within 60 days following Your original request if You have already received the services. You will be notified within **1 day** after the panel decision. If You fail to provide records or other information that We need 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 Molina's panel, can I still request the IRO review?

Yes. If Your request has been reviewed by Molina's panel and You are still dissatisfied with the decision, You will have **4 months** to decide whether You want to request a review by the IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a

single reviewer to consider Your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with Molina or with You. The reviewer will consider all of the information that is provided by Us and by You. (OSI can assist You in getting Your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

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

The IRO's fees are billed directly to Us – 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 of the information it needs to review the matter.)

Review by the Superintendent of Insurance

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

The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order

There is no charge to You for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to Molina. 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 Molina, You have a right to request an internal review within **180 days** after the date You are notified of the decision. We 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?

We will mail a decision to You within **30 days** after receiving Your request for a review of an administrative decision. .

Can I appeal the decision from the internal reviewer?

Yes. You have **20 days** to request that Molina form a committee to reconsider Our administrative decision.

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

When Molina receives Your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of Molina who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after Molina receives Your request. You will be notified at least 5 days prior to the committee meeting so that You may provide information, and/or attend the hearing in person or by telephone.

If You are unable to prepare for the committee hearing within the time set by Us, 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 Molina. You may submit the request to OSI using forms that are provided by Us. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674.

How does the external review work?

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

General Information

Confidentiality

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

Special needs and cultural and linguistic diversity

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

Reporting requirements

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

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

OTHER

CONTINUATION OF COVERAGE

Any Dependent of the Subscriber covered under this EOC will have the right to continue coverage under this EOC or to enroll in any other health plan product on the Marketplace at the applicable time upon 1) the death of the Subscriber or 2) 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 or, include coverage to Dependent children for whom the Spouse or has responsibility for care and support. These rights established by this EOC 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 EOC shall not exist with respect to any covered family member of the Subscriber in the event the coverage under this product terminates (a) for cancelation of this Agreement by Subscriber, (b) nonpayment of premium, (c) nonrenewal of this Agreement or (d) the expiration of the term for which this Agreement has been issued. With respect to any covered family member who is eligible for Medicare or any other similar federal or state health insurance program, the right to a continuation of coverage under this section shall be limited as provided by any applicable law. Individuals that qualify for Medicare due to End-Stage Renal Disease (ESRD)/kidney failure disease may be allowed to continue their coverage under this EOC and continue to receive federal premium tax credit, if deemed eligible by the Marketplace.
- Coverage continued under this EOC or under any other product that Molina Healthcare 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 Healthcare. 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 Healthcare will provide each covered family member under this EOC who is 18 years of age or older a statement setting forth in summary form the continuation of coverage provisions established by this "Continuation of Coverage" section.
- The eligible covered family member exercising the continuation of coverage as established in this "Continuation of Coverage" section must notify Molina Healthcare and make payment of the applicable premium within 30 days following the date that coverage under this EOC terminates as specified in the termination provisions of this EOC.
- The rights established in this "Continuation of Coverage" section can only be exercised to the extent of applicable law. For example, a covered family member under this EOC 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 You and Your Dependents on a guaranteed issue basis, this "Continuation of Coverage" section will only apply to Your Dependents if Molina Healthcare is required, at the time, by applicable law to provide such coverage.

Additional required provisions

Entire Contract; Changes
This EOC, together with its endorsements, riders, amendments, and attached papers, if any, constitute the entire agreement and contract of insurance between Molina Healthcare, on the one hand, and the Subscriber and Dependents covered by this EOC, on the other hand. No amendment, modification or other change to this EOC shall be valid until approved by an executive officer of Molina Healthcare and evidenced by a written document signed by the executive officer. No agent of Molina Healthcare has authority to change this EOC or to waive any of its provisions.

Notice of Claim

Written notice of a Member's claim relating to Covered Services under this EOC, when applicable (a "**Claim**") must be given to Molina Healthcare within 20 days after the Claim for reimbursement or payment of Covered Services under this EOC becomes owing, or as soon thereafter as is reasonably possible. Notice of the Claim given by or on behalf of the Member to Molina Healthcare at the following address, with information sufficient to identify the Member and the nature of the Claim, shall be deemed notice to Molina Healthcare:

Molina Healthcare
P.O. Box 22801
Long Beach, CA 90802

Upon Your submission of a Claim to Molina Healthcare, Molina will calculate the amount of the Claim that may be due to You in accordance with this Agreement and applicable state and federal laws. If amounts subject to the Claim are owing to You, such amounts may be reduced by applicable Cost Sharing.

Claim Forms

Molina Healthcare, upon receipt of a notice of Claim from a Member as provided above, 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.

Proof of Loss

If required or appropriate as determined by Molina Healthcare, written proof of loss relating to a Claim must be furnished to Molina at its office (identified in the "Notice of Claim" section above) within 365 days after the occurrence or start of the loss on which the Claim is based to validate and preserve the Claim. If written proof of loss is not given within that time, the Claim will not be invalidated, denied or reduced if it is shown that written proof of loss relating to a Claim was given as soon as was reasonably possible or legal incapacity of the Member extended the time period for providing such proof of loss. Foreign Claims and proof of loss relating to such Claims must be translated in U.S. currency prior to being submitted to Molina Healthcare.

Time of Payment of Claims

Upon the timely receipt of the proof of loss (if required by Molina Healthcare) and all other information necessary to evaluate, process and pay a Claim under this EOC, Molina Healthcare will pay the Claim within 60 days after receipt of such proof of loss and other information. Payment of Claims by Molina requires that documentation, however submitted to Molina, be in form and content reasonably acceptable to Molina and contain all required information for processing without the need for additional information from outside of Molina Healthcare. Interest penalties will not be applied to Claims not paid within the timeframes stated.

Payment of Claims for Deceased Member

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

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.

Legal Actions

No action at law or in equity and no proceeding to arbitrate shall be brought to recover under this EOC prior to the expiration of 60 days after a Claim and, if applicable, written proof of loss have been furnished in accordance with the requirements of this EOC. No such legal or equitable action and no such arbitration shall be brought after the expiration of three years after the time written proof of loss is required to be furnished, if applicable, and if no such proof of loss is required by Molina Healthcare, then three years after the time the Claim is required to be furnished.

Change of Beneficiary

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

The Rights of Custodial Parents

When a child has health coverage through a noncustodial parent, Molina Healthcare 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 Healthcare 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 Healthcare, 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 Healthcare 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 Healthcare is notified that the Member receives benefits under the Medicaid program and that the indemnity benefits payable by Molina must be paid directly to HSD (the notice may be accomplished through an attachment to the claim by HSD for the indemnity benefits when the claim is first submitted by HSD to Molina).

Members Eligible for Medicare

Each Member entitled to coverage under Medicare must notify Molina Healthcare in writing.

Changes to this Agreement; No Agent Authority

Without limiting the general provisions above, no agent or other person, except an executive officer of Molina Healthcare, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making payment, or to bind Molina Healthcare by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidence by an endorsement or amendment in writing to this Agreement signed by such executive officer.

MISCELLANEOUS PROVISIONS

Acts Beyond Molina Healthcare's Control

If circumstances beyond the reasonable control of Molina Healthcare, 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 Healthcare and the Participating Provider shall provide or attempt to provide Covered Services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina Healthcare 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 Healthcare'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 Healthcare's right to require Your performance of any provision of this Agreement.

Non-Discrimination

Molina Healthcare does not discriminate in hiring staff or providing medical care based on pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex , sexual orientation and/or gender identity.

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1(888) 295-7651.

Organ or Tissue Donation

You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. You may choose to be an organ tissue donor by registering with the New Mexico Motor Vehicle Division when You apply for or renew Your Driver's License or by going online at www.nmdonor.com to add Your name to the registry.

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

You 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 (which consent may be refused in Molina's discretion).

Governing Law

Except as preempted by federal law, this Agreement will be governed in accordance with New Mexico law and any provision that is required to be in this Agreement by state or federal law shall bind Molina Healthcare 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 or binding arbitration, 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 Healthcare under this Agreement will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for reporting any change in address by contacting the Marketplace at 1 (800) 318-2596.

Wellness Programs

Your Agreement includes access to a health activity program. The goal of the program is to encourage You to complete a health activity that supports Your overall health. The program is voluntary and available at no additional cost to You. The health activity we encourage you to complete, is described below. For more information, please contact Member Services phone number on your ID Card.

Annual Health Activity

We encourage You to complete the annual health activity below, during the calendar year. Upon completion, Molina may work with You to support Your overall wellness.

Annual Wellness Exam

- Provides You with the opportunity to obtain either an annual comprehensive physical exam through your Primary Care Provider, or an In-home health assessment exam facilitated through Molina

HEALTH EDUCATION PROGRAMS

The tools and services described here are educational support for Our Members. We may change them at any time as necessary to meet the needs of Our Members.

HEALTH EDUCATION

Molina Healthcare offers programs to help You and Your family manage a diagnosed health condition. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management

You can get information or join any of the programs above by calling the Molina Health Management Department at 1 (866) 891-2320 9:30 a.m. and 6:30 p.m. (MT), Monday through Friday. You may also call us if you wish to stop receiving program materials.

Newsletters

Newsletters are posted on the www.MolinaHealthcare.com website at least 2 times a year. The articles are about topics asked by members like you. The tips can help you and your family stay healthy.

Health Education Materials

Our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, ask your doctor or visit our website at:MolinaMarketplace.com/MPHealthEducation.

YOUR HEALTHCARE QUICK REFERENCE GUIDE

Department/Program	Type of help needed	Number to call/ Contact information
Molina Healthcare Customer Support Center Department	If You have a problem with any of Molina Healthcare's services, we want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00 am to 5:00 pm. MT. When in doubt, call Us first.	Customer Support Center Toll Free: 1 (888) 295-7651 TTY line for the deaf or hard of hearing: 1 (800) 659-8331 or dial 711 for the Telecommunications Service
Health Education	. To request any information on programs for conditions such as asthma, diabetes, high blood pressure, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD)	1 (866) 891-2320 9:30 a.m. and 6:30 p.m. MT Monday through Friday
Nurse Advice Line 24-Hour, 7 days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750 for Spanish:1 (866)648-3537
Maternity, Weight Management and Smoking Cessation	Information regarding these health matters are available at the Molina Marketplace website.	MolinaMarketplace.com
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that we have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	(800) 368-1019 TDD for deaf or hard of hearing: (800) 537-7697 FAX: (214) 767-0432
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE TTY for deaf or hard of hearing: 1 (877) 486-2048 www.Medicare.gov
New Mexico Office of Superintendent of Insurance	The New Mexico Office of Superintendent of Insurance is responsible for regulating health care services plans. If You have a grievance against Molina Healthcare, You should first call Molina Healthcare toll-free at 1 (888) 295-7651, and use Molina Healthcare's grievance process before contacting this Office.	1-855-4ASK-OSI (1-855-427-5674)