MOLINA HEALTHCARE

8801 Horizon Blvd. NE
Albuquerque, NM 87113

MolinaHealthcare.com/Marketplace

Product offered by Molina Healthcare of New Mexico, Inc.,
a wholly owned subsidiary of Molina Healthcare, Inc.

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MHNM01012015

2015

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

Molina Marketplace Bronze Plan

New Mexico

8801 Horizon Blvd. NE, Albuquerque, NM 87113

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKAN NATIVE. 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. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.

MolinaHealthcare.com/Marketplace

MOLINA HEALTHCARE
Your Extended Family.

MHNM01012015

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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 Benefits and Coverage 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'll 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
8801 Horizon Blvd. NE
Albuquerque, NM 87113
1(888) 295-7651
www.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 National Relay Service.

MOLINA HEALTHCARE OF NEW MEXICO, INC.
BENEFITS AND COVERAGE GUIDE
(SUMMARY OF BENEFITS)

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS. IT IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF NEW MEXICO, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS.

Deductible Type	You Pay
Combined Medical and Pharmacy Deductible (Deductible waived for preventive, first three office visits and Generic Drugs)	
Individual	$4,500
Entire Family of 2 or more	$9,000

Annual Out of Pocket Maximum	You Pay
Individual	$6,600
Entire Family of 2 or more	$13,200

Emergency Room and Urgent Care Services	You Pay	
Emergency Room*	$300	Copayment per visit
Urgent Care	$75	Copayment per visit

*This cost does not apply, if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital Services, for applicable Cost Sharing to You)

Outpatient Professional Services**	You Pay	
Office Visits		
Preventive Care Services (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$25	Copayment per visit
Specialty Care	$75	Copayment per visit
Other Practitioner Care	$75	Copayment per visit
Habilitative Services	40%	Coinsurance
Rehabilitative Services	40%	Coinsurance

Mental/Behavioral Health Services	$25	Copayment per visit
Substance Abuse Disorder Services	$25	Copayment per visit
Dental Services Related to Accidental Injury	40%	Coinsurance
Pediatric Vision Services (for Members under Age 19 Only) (If applicable, Pediatric Vision Services will be furnished pursuant to "Pediatric Vision Services Rider No. 2 Molina Marketplace" which is a part of this EOC.)		
Hearing Aids for Children (For Dependent children under 18 years of age or under 21 years of age if still attending high school) • Hearing aids costing up to $2200 (limit 1 hearing aid every 36 months)	No Charge	
• Hearing aids costing in excess of $2200	40%	Coinsurance
Family Planning	No Charge	

****General medical care provided by a Participating Provider**

Outpatient Hospital / Facility Services		**You Pay**
Outpatient Surgery		
Professional	40%	Coinsurance
Health Care Facility (e.g., Ambulatory Surgical Center)	40%	Coinsurance
Endoscopic Procedures (Medically Necessary exams, tests and procedures). Endoscopic procedures covered as preventive care services in accordance with the provisions of this EOC are not subject to the Medically Necessary requirement, and such procedures will be at no charge.	40%	Coinsurance/visit
Administration of Injections and Infusion Therapy	40%	Coinsurance
Specialized Scanning Services		
CT Scan	40%	Coinsurance
PET Scan	40%	Coinsurance

MRI	40%	Coinsurance
Radiology Services	$75	Copayment
Chemotherapy	10%	Coinsurance
Laboratory Tests	$30	Copayment
Mental/Behavioral Health Services		
Outpatient Intensive Psychiatric Treatment Programs	40%	Coinsurance

Inpatient Hospital Services	**You Pay**	
Medical / Surgical		
Professional	40%	Coinsurance
Health Care Facility	40%	Coinsurance
Maternity Care (professional and facility services)	40%	Coinsurance
Mental/Behavioral Health Services (Inpatient Psychiatric Hospitalization)	40%	Coinsurance
Substance Abuse Disorder Services		
Inpatient Detoxification	40%	Coinsurance
Transitional Residential Recovery Services	40%	Coinsurance
Skilled Nursing Facility (limited to 60 days per calendar year)	40%	Coinsurance
Hospice Care	No Charge	

Prescription Drug Coverage	**You Pay**	
Formulary Generic Drugs	$16	Copayment
Formulary Preferred Brand Name Drugs	$65	Copayment
Formulary Non-Preferred Brand Name Drugs	40%	Coinsurance
Specialty Drugs (Oral and Injectable Drugs)	40%	Coinsurance

Please refer to 56-60 for a description of prescription drug coverage.

Ancillary Services	**You Pay**

Durable Medical Equipment	40%	Coinsurance
Home Health Care (Limited to 100 visits per year)	$75	Copayment per visit
Emergency Medical Transportation (Ambulance)	$100	Copayment
Non-Emergency Medical (Combined Non-Emergency Medical and Non-Emergency Non-Medical Transportation limit of 4 round trips per month)	Not Covered	
Non-Medical Transportation (Combined Non-Emergency Medical and Non-Emergency Non-Medical Transportation limit of 4 round trips per month)	Not Covered	

Other Services	**You Pay**	
Dialysis Services	$75	Copayment
Chiropractic Services	$75	Copayment
Acupuncture Services	$75	Copayment

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. Read the sections that apply to You.

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:

- Choose a doctor
- Make an appointment
- Arrange for an interpreter

We can also listen and respond to Your questions or complaints. You can ask us about Your benefits with Molina. We can help with concerns about Your doctor or other Molina services.

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 National Relay Service.

Call us if You move from the address You had when You enrolled with Molina. Let us know if You change phone numbers. Please contact Our Customer Support Center to update that information.

Share Your updated address and phone number with Molina. This will help us give You information. We can send You newsletters and other materials. We can reach You by phone if We need to contact You.

YOUR PRIVACY

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

Your Protected Health Information

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

Why does Molina use or share Our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run Our health plan
- To use or share PHI for other purposes as required or permitted by law. Examples include for public health and health care oversight purposes. Please see page 8 of this EOC for more details.

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

What are Your privacy rights?

- You can look at Your PHI
- You can get a copy of Your PHI
- You can amend Your PHI
- You can ask us to not use or share Your PHI in certain ways. Examples include restrictions on sharing Your PHI with family members or certain other persons. Please see page 9 of this EOC for more details.
- You can get a list of people or places We have given Your PHI

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

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

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

NOTICE OF PRIVACY PRACTICES

MOLINA HEALTHCARE OF NEW MEXICO, INC.

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

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

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

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

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

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

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

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

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

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

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

- **Required by Law**

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

- **Public Health**

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

- **Health Care Oversight**

Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

- **Research**

Your PHI may be used or shared for research.

- **Law Enforcement**

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

- **Health and Safety**

Your PHI may be shared to prevent a serious threat to public health or safety.

- **Government Functions**

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

- **Victims of Abuse, Neglect or Domestic Violence**

Your PHI may be shared with legal authorities if We believe that a person is a victim of abuse or neglect.

- **Workers Compensation**

Your PHI may be used or shared to obey Workers Compensation laws.

- **Other Disclosures**

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

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?

Molina needs Your written approval to use or share Your PHI for any reason not listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following: (1)

most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given us. Your cancellation will not apply to actions already taken by us.

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

- **Request Restrictions on Sharing of Your PHI**

You may ask us not to share Your PHI to carry out treatment, payment or health care operations. You may also ask us not to share Your PHI with family or other persons You name who help in Your health care. However, We are not required to agree to Your request.

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

- **Request Confidential Communications of PHI**

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

- **Review and Copy Your PHI**

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

- **Amend Your PHI**

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

- **Sharing of Your PHI**

You may ask that we give You a list of certain parties that we shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with Your authorization;
- incident to a use or disclosure otherwise permitted or required under applicable law;
- as part of a limited data set in accordance with applicable law.

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

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

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

You may complain to us at:

Customer Support Center
8801 Horizon Blvd., NE
Albuquerque, NM 87113
1 (888) 295-7651

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

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

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

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

This Notice is Subject to Change

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

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

Customer Support Center
8801 Horizon Blvd., NE

Albuquerque, NM 87113
1 (888) 295-7651

HELP FOR NON-ENGLISH SPEAKING MOLINA MEMBERS

Interpreter Request Cards
As a Molina Member, You have access to interpreter services 24 hours a day. An interpreter request card is sent to all new Members after initial enrollment with Molina.

You do not need to have a minor, friend or family member act as Your interpreter. You may wish to say things that You do not wish to share with a minor, friend or family member. Using an interpreter may be better for You.

Keep the Interpreter Request Card in Your wallet. If Molina has wrong information about Your language needs call us. The Customer Support Center is toll-free at 1 (888) 295-7651.

What is printed on the card?
The English side of the Interpreter Request Card says what language You speak. It also says that Molina Healthcare will pay for Your interpreter. The card tells staff how to get You an interpreter.

The English text reads as follows:
Hello. I speak SPANISH (or another language). I need an interpreter. My health care plan, Molina Healthcare, will pay for an interpreter if You do not have one here. Please call 1 (888) 295-7651 and state, "I have a Molina patient and I need an interpreter."

How do I use the card?
Show the Interpreter Request Card to staff at these places:
• Your doctor's office or clinic
• Labs, clinics, or other medical service offices
• The pharmacy where You get Your medicine
• The emergency room at a hospital

Show the English side of the card to the person helping You. The office or pharmacy may have a staff person who speaks Your language. If they do not, they will call a telephone interpreter service. You will be able to discuss and get the information You need using the telephone interpreter.

Call us if You have any questions.
Customer Support Center toll-free at:
1 (888) 295-7651

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 711 for the National Relay Service.

If You need help understanding the enclosed information in Your language, please call Molina Healthcare Customer Support at 1(888) 295-7651.

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."**Annual Out-of-Pocket Maximum**"

- **For Individuals** - is the total amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Certificate are specified in the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide. For this Certificate, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the individual Annual Out-of-Pocket Maximum.

- **For Family (2 or more Members)** – is the total amount of Cost Sharing that at least two or more Members of a family will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your Certificate are specified in the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide. For this Certificate, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the family Annual Out-of-Pocket Maximum.

"**Authorization or Authorized**" means a decision to approve specialty or other Medically Necessary care for a Member by the Member's PCP, medical group or Molina. An Authorization is usually called an "approval."

"**Benefits and Coverage**" (also referred to as "**Covered Services**") means the healthcare services that You are entitled to receive from Molina under this Agreement.

"**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.

"**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. Benefits and Coverage Guide. 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. Benefits and Coverage Guide. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

"**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. Benefits and Coverage Guide at the beginning of this EOC.

"**Cytological Screening**" means a papanicolauo 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. Benefits and Coverage Guide. Please refer to the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide 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 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:

(i) when You meet the Deductible for the individual Member; or
(ii) 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.

"**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 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: 1) jeopardy to the person's health; 2) serious impairment of bodily functions; 3) serious dysfunction of any bodily organ or part; or 4) disfigurement to the 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 the person's health
- serious impairment of bodily functions
- serious dysfunction of any bodily organ or part
- disfigurement to the 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 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 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, however; it may be organized and run.

"**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 any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by Molina Healthcare consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

"**Member**" means an individual who is eligible and enrolled under this Agreement, and for whom We have received applicable Premiums. The term includes a Subscriber and a Dependent. This EOC sometimes refers to a Member as "You" or "Your."

"**Molina Healthcare of New Mexico, Inc. ("Molina Healthcare" or "Molina")**" means the corporation licensed by New Mexico as a Health Maintenance Organization, and contracted with the Marketplace. This EOC sometimes refers to Molina Healthcare as "we" or "Our".

"**Molina Healthcare of New Mexico Agreement and Individual Evidence of Coverage**" means this booklet, which has information about Your benefits. It is also called the "EOC" or "Agreement."

"**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.

"**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**") 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 specialist physicians or other services. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctors who usually can see the whole family.
- Internal medicine doctors, who usually only see adults and children 14 years or older.
- Pediatricians, who see children from newborn to age 18 or 21.
- Obstetricians
- Gynecologists.
- Doctor of the Healing Arts

"**Primary Care Provider**" or "**PCP**" means 1) a Primary Care Doctor, 2) an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor, or 3) a Doctor of the Healing Arts who within the scope of his or her license is authorized to provide primary care services.

"**Referral**" means the process by which the Member's Primary Care Doctor directs the Member to seek and obtain Covered Services from other providers.

"**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 geographic area in New Mexico where 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 any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

"**Spouse**" means the Subscriber's legal husband or wife.

"**Subscriber**" means an individual who is a resident of New Mexico, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare in accord with the terms of this Agreement.

"**Urgent Care Services"** mean 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.

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 2015, the initial open enrollment period begins November 15, 2014 and ends February 15, 2015. Your Effective Date for coverage during 2015 will depend on when You applied:

• If You applied on or before December 15, 2014, the Effective Date of Your coverage is January 1, 2015.

If You applied between December 16, 2014 and January 15, 2015, the Effective Date of Your coverage is February 1, 2015.

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. 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 for these requirements. Molina requires You to live or work in Our Service Area for this product. 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 Benefits and Coverage)."

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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 live or work in Our Service Area for this product. The following family members are considered Dependents:

- Spouse
- Children:
    - The Subscriber's children; or
    - His or her Spouse's children
    - Legally adopted children and stepchildren.
- Each child may apply for enrollment as a Dependent until the age of 26. This is the limiting age.
- Subscriber's grandchildren do not qualify as Dependents.

Domestic Partners: A domestic partner of the Subscriber may be allowed to enroll in this product during an open enrollment period. If enrollment of domestic partners is available, the domestic partner of the Subscriber must:

- Share a permanent residence with the Subscriber;
- Have resided with the Subscriber for not less than one year (365 days);
- Be at least 18 years of age;
- Be financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two of the following arrangements:
    - Common ownership of real property or a common leasehold interest in such property;
    - Common ownership of a motor vehicle;
    - A joint bank account or a joint credit account;
    - Designation as a beneficiary for life insurance or retirement benefits or under the Subscriber's last will and testament;
    - Assignments of a durable power of attorney or health care power of attorney; or
    - Such other proof as is considered by Molina Healthcare to be sufficient to establish financial interdependency under the circumstances of a particular case;
- Not be a blood relative any closer than would prohibit legal marriage;
- Have signed jointly with the Subscriber a notarized affidavit in form and content as may be requested by Molina Healthcare; and
- Have registered with the Subscriber as domestic partners if You reside in a state that provides for such registration.

PLEASE NOTE:

A person is not eligible to enroll as a domestic partner if either such person or the Subscriber has signed a domestic partner affidavit or declaration with any other person within twelve (12) months prior to designating each other as domestic partners under this product; are currently legally married to another person; or have any other domestic partner, Spouse or Spouse equivalent of the same or opposite sex. An eligible domestic partner's natural or adopted children who meet the Dependent eligibility requirements for enrollment in this product are also eligible to enroll as Dependent children.

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 by reason of 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 60 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 subsequent proof of continued incapacity and dependency, but not more frequently than annually following the two-year period after the child's attainment of age 26.

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

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 or a newly adopted child), You must contact Molina Healthcare and/or 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 Molina Healthcare and/or 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 or domestic partnership arrangement.
  - The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **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, or adoption.
  - The child, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **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 for only 31 days (including the date of birth).

- **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 have 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 product if the child's parent is covered under this product 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 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 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 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.

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

Discontinuation of Dependent Benefits and Coverage: Benefits and Coverage for Your Dependent will be discontinued on:

- The date the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children.
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage from the Subscriber.
- The date the Dependent Domestic Partner enters a termination of the domestic partnership from the Subscriber.

Continued Eligibility: A Member is no longer eligible for this product 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 product, We will send You a letter letting You know at least 10 days before the effective date on which You will lose eligibility. At that time, You can appeal the decision.

MEMBER IDENTIFICATION CARD

HOW DO I KNOW IF I AM A MOLINA HEALTHCARE MEMBER?

You get a Member identification (ID) card from Molina Healthcare. Your ID card comes in the mail. Your ID card lists Your Primary Care Doctor's name and phone number. 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, call 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 will tell You the name of Your doctor. This person is called Your Primary Care Doctor or PCP. This is Your main doctor. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- Your Primary Care Doctor's name (Provider)
- Your Primary Care Doctor's office phone number (Provider Phone)
- The name of the medical group Your PCP is associated with (Provider Group)
- Molina Healthcare's 24 hours Nurse Advice Line toll-free number
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription related questions and the identifier for Molina Healthcare's prescription drug benefit
- Toll free number for hospitals to notify Molina Healthcare of admissions for Our Members
- Toll free number for emergency rooms to notify Molina Healthcare of emergency room admissions for Our Members

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 www.molinahealthcare.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.

Here is a chart to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. Find the service You need, look in the box just to the right of it and You will find out where to go.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO 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 out-of-area Urgent Care Services You may also go to the nearest urgent care center or emergency room.
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

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
	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 qualified mental health Participating 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, a Referral from Your qualified mental health Participating Provider is needed.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
To have surgery	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
To get a second opinion	Consult Your Provider Directory. You go to Our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.
To go to the Hospital	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
After-hours care	Call Your PCP for a Referral to an after-hours clinic or other appropriate care center. 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.

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 product, Your health care services must be received from Molina Healthcare Participating Providers (doctors, hospitals, specialist physicians or medical clinics), except in the case of Emergency Services or out of area Urgent Care Services. Please see page 32 for more information about the coverage of Emergency Services and out of area Urgent Care Services.

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. Your Provider Directory was included in the materials You received from us. If You did not get a Provider Directory, then please call Molina's Customer Support Center toll free at 1(888) 295-7651.

You can find the following in Your 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's 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 choose a PCP that You feel comfortable with.

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. However, if You don't choose a PCP, we will choose one for You.

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:

1) a hospital for hospital care which is covered under this EOC, or

2) 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 www.molinahealthcare.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 completed by the 25th of the month will be in effect on the first day of the next calendar month. Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month. But 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 Doctor Request that I Change to a Different Primary Care Provider?

Your doctor 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 www.molinahealthcare.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.

If You are assigned to a PCP or hospital that is ending a contract with Molina, then Molina will provide You with not less than 30 days advance written notice of such a contract ending between Molina and PCP or acute care hospital. Transition of care services may be available for existing Members with certain medical conditions and those in their 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 National Relay Service. You can also ask for a copy of Molina's policy that talks about staying with a doctor or hospital.

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 National Relay Service. Call by dialing 711. The Nurse Advice Line is staffed by Registered Nurses. They are open 24 hours a day, 365 days a year.

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.

WHAT IS A PRIOR AUTHORIZATION?

A **Prior Authorization** is a request for You to receive a Covered Service from Your doctor. Molina's Medical Directors and Your doctor all work together. They decide on the Medical Necessity before the care or service is given. This is to ensure it is the right care for Your specific condition.

You do not need Prior Authorization for the following services:

- Emergency or Urgent Care Services
- To see an OB/GYN. Women may self-refer for this.
- Family planning services
- Human Immunodeficiency Virus (HIV) testing & counseling
- Services for sexually transmitted diseases

You must get Prior Authorization for the services below. This does not apply for Emergency or Urgent Care.

- All inpatient admissions
- Bariatric surgery referral and surgery

- Surgery or other procedures to correct diagnosed infertility. This is subject to "Exclusions" from coverage.
- Cardiac and pulmonary rehabilitation
- Certain injectable drugs. Medications not listed on the Molina Drug Formulary.
- Cosmetic, plastic and reconstructive procedures.
- Admission in a hospital or ambulatory care center for dental care. General anesthesia for dental care in Members 5 years old or older.
- Dialysis. Notify us.
- Durable Medical Equipment that costs more than $500.
- All custom orthotics. All custom prosthetics and braces. Examples are:
    - Special braces
    - Shoes or shoe supports
    - Any kind of wheelchair
    - Scooters
    - Implanted hearing device
- Enteral formulas and supplies
- Nutritional supplements and supplies
- Experimental and Investigational procedures
- Habilitative services
- Home health care
- Hospice inpatient care . Notify us.
- Imaging and special tests. Examples are:
    - CT (computed tomography)
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiogram)
    - cardiac scan
    - PET (positron emission tomography) scan
- Mental and behavioral health services
- Office based podiatry (foot) surgery
- Some Outpatient hospital service*
- Some ambulatory surgery center service**
- Pain management care and procedures
- Pregnancy and delivery. Notify us.
- Rehabilitative services
- Specialty pharmacy
- Substance abuse disorder treatment
- Transplant evaluation and related service
- Transportation. This is for non-emergent ground and air ambulance. Must be medically necessary. Examples are special vans service or ambulance.
- Diagnosis or treatment plan for Autism Spectrum Disorder
- Any other services listed as needing Prior Authorization in this EOC.

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

If 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 need. Call us if You have questions about how a certain service is approved. 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 National Relay 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 10 calendar days from the receipt of the request. This would be if we can show a reasonable cause beyond Our control. We would also need to show that the delay will not result in a medical risk to You. We would provide You with a written progress report.

Medical conditions that may cause a serious threat to Your health are processed 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. The time required may be shorter under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina processes requests for urgent specialty services right away. This is done by phone.

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 on page 92 of this EOC.

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. If You have a standing approval to a specialist physician You will not need to get a Referral each time You see that doctor.

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 National Relay Service.

If You feel Your needs have not been met please see Molina's grievance process on page 83.

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 www.molinahealthcare.com.

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 are services needed to evaluate, stabilize or treat an **Emergency Medical Condition.** An Emergency Condition includes:

- A medical condition with acute and severe symptoms. This includes severe pain.
- A psychiatric condition with acute and severe symptoms
- Active labor.

If medical attention is not received right away, an Emergency could result in:

- Placing the patient's health in serious danger.
- Serious damage to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Disfigurement to the person.

Emergency Care also includes Emergency contraceptive drug therapy.

Emergency Care includes Urgent Care Services that cannot be delayed. This is needed to prevent serious deterioration of health from an unforeseen condition or injury.

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 take 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 National Relay 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 Urgent Care Services or Emergency Services are covered.

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

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 urgent care center and the name of the hospital that You are to use.

If You are outside of Molina's Service Area You may go to the nearest urgent care center or emergency room.

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.

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 Benefits and Coverage Guide.

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 National Relay Service.

PREGNANCY

What if I am pregnant?

If You are pregnant or think You are pregnant please call us. Early prenatal care is very important for You and Your baby's health and well-being.

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.

Molina offers a special program called Motherhood Matters. This if for Our pregnant Members. This program provides important information about diet, exercise and other topics about pregnancy. For more information call the Motherhood Matters pregnancy program. The toll-free number is 1 (877) 665-4628. We are here Monday through Friday, 8:00 a.m. to 5:00 p.m.

ACCESS TO CARE FOR MEMBERS WITH DISABILITIES

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of 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. Tell us when You make Your appointment. Molina requests at least 72 hours advance notice to arrange for services with a qualified interpreter. It is Our goal to have an interpreter meet You at the doctor's office. Call Molina Healthcare's Customer Support Center. The TTY Number is toll-free at 1 (800) 659-8331. You may also use the National Relay 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.

BENEFITS AND COVERAGE

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 offered through the Marketplace, except where specifically noted to the contrary in this EOC. For example, in the case of an Emergency or need for out-of-area 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. Benefits and Coverage Guide at the beginning of this EOC.

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. Benefits and Coverage Guide at the beginning of this EOC. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members. This is determined by the Marketplace's rules.

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

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum is the total amount of Cost Sharing You may have to pay for Covered Services in a calendar year. The Annual Out-of-Pocket Maximum is specified in the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide. The Annual Out-of-Pocket Maximum includes payments You have made towards the Deductible, Copayments, and Coinsurance.

There may be an Annual Out-of-Pocket Maximum listed for the Member. There may also be an Annual Out-of-Pocket Maximum for a Family. If You are a Member in a Family of two or more Members, You will reach the Annual Out-of-Pocket Maximum in one of two ways.

(i) when You meet the Annual Out-of-Pocket Maximum for the Member, or
(ii) when Your Family reaches the Out-of-Pocket Maximum for the Family.

For example, if You reach the Annual Out-of-Pocket Maximum for the Member, You will not pay any more Cost Sharing for the calendar year. Every other Member in Your Family must continue to pay Cost Sharing for the calendar Year until Your Family reached the Annual Out-of-Pocket Maximum for the 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. Benefits and Coverage Guide. 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. Benefits and Coverage Guide. 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. Benefits and Coverage Guide.
Please refer to the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide 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 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:

(i) when You meet the Deductible for the individual Member; or
(ii) 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, unless specifically stated or until You pay the Annual Out-of-Pocket Maximum. Please refer to the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide at the beginning of this EOC. 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 a portion 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 treatment which are <u>not</u> Covered Services under this EOC.

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 vision services..

The Affordable Care Act provides certain rules for Essential Health Benefits. These rules apply to how Molina administers Your product 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 Benefits and Coverage or 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. Turn to page 83 for information on how You can have Your case reviewed. See the 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. Turn to page 96 for information. Molina also may cover

routine medical costs for Members in Approved Clinical Trials. Turn to page 52 to learn more.

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 pages 29 – 30. Prior Authorization will never apply to treatment of Emergency Conditions or for 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;

- 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.

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 a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the Affordable Care Act and applicable New Mexico law. These coverage limitations also are applicable to the preventive care benefits listed below.

To help You understand and access Your benefits, preventive services for adults and children

which are covered under this EOC are listed below.

Preventive Care 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:

- Well baby/child care
- Complete health history
- Physical exam including growth assessment
- Nutritional health assessment
- Vision screening
- Dental screening
- Speech and hearing screening
- Immunizations*****
- Laboratory tests, including tests for anemia, diabetes, cholesterol and urinary tract infections
- Tuberculosis (TB) screening
- Sickle cell trait screening, when appropriate
- Health management
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of the exam
- 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.)
- All comprehensive perinatal services are covered. This includes: perinatal and postpartum care, healthmanagement, nutrition assessment and psychological services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (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.)
- Depression screening: adolescents
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation in children when prescribed by a Participating Provider
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns

*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 Care 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

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- 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.)
- Cytological Screening (pap smear) for women beginning no later than age 18 (also based on Your health status and medical risk.)
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening
- Osteoporosis screening for women (based on Your age)
- Immunizations
- Laboratory tests for diagnosis and treatment (including diabetes and STD's)
- Health management and chronic disease management
- 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.)
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Breastfeeding support, supplies counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing exams and screenings
- Eye exams and preventive vision screenings
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA counseling about breast cancer preventive medication
- Chlamydial infection screening: women
- Depression screening: adults

- Dietary evaluation and nutritional counseling
- Obesity screening and counseling: adults
- STDs and HIV screening and counseling
- Tobacco use counseling and interventions
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed)
- Screening and counseling for interpersonal and domestic violence: women

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):

- Prevention, diagnosis, and treatment of illness or injury
- Office visits (including pre- and post-natal visits)
- Routine pediatric and adult health exams
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Injections, allergy tests and treatments when provided or referred by Your PCP
- Audiology and hearing tests
- Physician and other Practitioner care in or out of the hospital
- Consultations and well child care
- 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
- If You are a female Member, You may also choose to see an Obstetrician-gynecologist (OB/GYN) for routine examinations and prenatal care. You may select an OB/GYN as Your PCP. Female Dependents age 13 and older have direct access to obstetrical and gynecological care.
- 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.)
- 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)

HABILITATIVE SERVICES

We cover Medically Necessary habilitative health care services and devices. The devices must be designed to assist individuals with performing routine activities of daily life successfully in their home and community based settings. This includes acquiring, retaining or improving self-help, socialization, functioning and adaptive skills. These services may include physical therapy, occupational therapy, speech therapy, personal attendant services and durable medical equipment.

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 care. You must receive care from 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
- Outpatient services for the purpose of monitoring drug therapy

We cover outpatient mental or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is identified in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The "mental disorder" results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"**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 below.

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 "Substance Abuse Disorder Services" section.

DENTAL AND ORTHODONTIC SERVICES

We do not cover most dental and orthodontic services. We do cover some dental and orthodontic services for Members as described in this "Dental and Orthodontic Services" 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. Molina may also authorize a Referral to a dentist.

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 Referral to a Non-Participating Provider who is a dentist or orthodontist.

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.

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, see "Inpatient Hospital Services" in the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide for the Cost Sharing that applies for hospital inpatient care.

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. 2 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. You shall not have any Cost-Sharing for a covered hearing aid which costs $2,200 or less. You may choose a hearing aid for a Dependent child which costs more than $2,200. You may purchase a hearing aid more frequently than once every 36 months. However, You will pay the excess cost for such hearing aids as Cost Sharing. These amounts will be counted toward Your Cost-Sharing 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 17 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 for Members age 19 years or younger, or age 22 years or younger if enrolled in high school:

- 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 for Autism Spectrum Disorder are limited to 25 visits per calendar year for each affected Dependent child. Treatment 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-IV-TR, fourth 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. Also, for the purposes of this section, **"high school"** means a school providing instruction for any of the grades 9 through 12.

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, 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 permission 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
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera
- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's)
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency
- 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

PREGNANCY TERMINATIONS

Molina covers pregnancy termination services. These services are subject to certain coverage restrictions required by the Affordable Care Act and by any applicable laws in the State of New Mexico.

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.

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.

(Prescription Drug 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 Medically Necessary specialized scanning services. They include CT Scan, PET Scan, cardiac imaging and MRI by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services.

RADIOLOGY SERVICES

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.

CHEMOTHERAPY

We cover chemotherapy when furnished by Participating Providers and Medically Necessary. Chemotherapy is subject to Cost Sharing.

LABORATORY TESTS

We cover the following services when furnished by Participating Providers and Medically Necessary., These services are subject to Cost Sharing:

- 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 PROGRAMS

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 out-of-area Urgent Care Services, Your hospital stay will be covered. This happens even if You do not have a Prior Authorization.

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

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 in consultation with Your physician. (Inpatient Hospital Services Maternity Cost Sharing will apply.)

- 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 and adopted children of the Subscriber or the Subscriber's Spouse or Domestic Partner. Coverage begins from the moment of the child's birth or adoption so long as the child is timely and properly enrolled in this product.

Coverage of a Member's newly born natural or adopted 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 psychiatric hospitalization in a Participating Provider hospital. Coverage includes room and board, drugs, and services of Participating Provider physicians. It also covers other Participating Providers who are licensed health care professionals acting within the scope of their license. We cover inpatient hospital mental or behavioral health services 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 most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"**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 ABUSE 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.

SUBSTANCE ABUSE DISORDER
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

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. You will continue to get care without interruption.

The SNF benefit is limited to 60 days per calendar year.

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 product. Please contact Molina for further information. You must receive Prior Authorization for all inpatient hospice care services.

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 product
- 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
- Received Prior Authorization or approval from Molina

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:
1) the study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy; or
2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3) the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. 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. Benefits and Coverage Guide.

Molina does not have an obligation to cover certain items and services which 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 Your product 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

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 are 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. Benefits and Coverage Guide.

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. Benefits and Coverage Guide.

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. A Participating Provider physician must provide a written Referral for care to a transplant facility and Molina must authorize the services, as described in the "Accessing Care" section, under "What is a Prior Authorization?".

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

- If either the physician or the referral 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 are 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. Benefits and Coverage Guide. 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, subject to applicable Cost Sharing under the following conditions:

- They are ordered by a Participating Provider treating You and the drug is listed in the Molina Healthcare Drug Formulary. Drugs approved by Molina's Pharmacy Department are also covered.
- 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. They must be ordered by a Participating Provider for a Covered Service. The drugs are obtained through a pharmacy that is in the Molina pharmacy network.
- The drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

Also, subject to applicable Cost Sharing, and as prescribed by a Participating Provider:

- 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.
- We cover for the human papillomavirus vaccine for female Members who are nine to fourteen years of age.

We cover brand name drugs, generic drugs, specialty oral and injectable drugs. Such prescription drugs must be obtained through Healthcare's contracted pharmacies within New Mexico.

Prescription drugs are covered outside of the state of New Mexico (out of area) for Emergency or Urgent Care services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 295-7651 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 659-8331 or contact us with the National 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) 295-7651. You may view a list of pharmacies on Molina Healthcare's website, www.molinahealthcare.com.

Molina Healthcare Drug Formulary (List of Drugs)
Molina Healthcare has a list of drugs that it will cover. The list is called 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 three months to talk about the drugs that are in the formulary. They review new drugs and changes in health care. They try to find the most effective drugs for different conditions. Drugs are added or taken off the Drug Formulary for different reasons. This could be:

- changes in medical practice
- medical technology
- when new drugs come on the market.

You can look at Our Drug Formulary on Our Molina Healthcare website. The address is www.molinahealthcare.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 295-7651. We are here Monday through Friday, 8:00 a.m. through 5:00 p.m. MT. If You are deaf or hard of hearing, call Our TTY line. The number is toll-free 1 (800) 659-833. You may dial 711 for the National Relay Service.

You can also ask us to mail You a copy of the Drug Formulary. A drug listed on the Drug Formulary does not guarantee that Your doctor will prescribe it for You.

Access to Drugs Which are Not Covered
Molina has a process to allow You to request clinically appropriate drugs that are not covered under Your product. Your doctor may order a drug that is not in the Drug Formulary that he or she feels is best for You. Your doctor may make a request that Molina cover the drug for You through Molina's Pharmacy Department. If the request is approved, Molina will contact Your doctor. If the request is denied, Molina Healthcare will send a letter to You and Your doctor. The letter will explain why the drug was denied.

You may be 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**.** Molina will cover specific non-Drug Formulary drugs. The prescriber must:

- Document in Your medical record;
- Certify that the Drug Formulary alternative has not been effective in Your treatment; or
- The Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed on the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide. 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. This would not be subject to Cost Sharing.

Out
Formulary Generic Drugs
Formulary Generic drugs are those drugs listed in the Molina Healthcare Drug Formulary which have the same ingredients as brand name drugs. To be FDA (government) approved the 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. Cost Sharing for Formulary Generic drugs are listed on the Molina Healthcare of New Mexico, Inc. Schedule of Benefits. You will be charged a Copayment for Formulary Generic Drugs.
If Your doctor orders a brand name drug and there is a Formulary Generic drug available, we will cover the generic medication.

If Your doctor says that You must have the brand name drug instead of the generic, he/she must submit a Prior Authorization request to Molina Healthcare's Pharmacy department.

Formulary Preferred Brand Name Drugs
Formulary Preferred Brand Name drugs are those drugs listed which, due to clinical effectiveness and cost differences, are designated as "Preferred" in the Molina Healthcare Drug Formulary. Formulary Preferred 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 Healthcare and Our pharmacy benefit manager. Cost Sharing for Formulary Preferred Brand Name drugs are listed on the Molina Healthcare of New Mexico, Inc. Schedule of Benefits. You will be charged a Copayment for Formulary Preferred Brand Name Drugs.
Formulary Non-Preferred Brand Name Drugs
Formulary Non-Preferred Brand Name drugs are those drugs listed in the Molina Healthcare Drug Formulary which are designated as "Non-Preferred" due to lesser clinical effectiveness and cost differences. Formulary Non-Preferred 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 Healthcare and Our pharmacy benefit manager. Cost Sharing for Formulary Non-Preferred Brand Name drugs are listed on the Molina Healthcare of New Mexico, Inc. Schedule of Benefits. You will be charged a Coinsurance for Formulary Non-Preferred Brand Name Drugs.

Specialty Oral and Injectable Drugs

Specialty drugs are prescription legend drugs within the Molina Healthcare Drug Formulary which:

- Are only approved to treat limited patient populations, indications or conditions; 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.

Molina Healthcare may require that Specialty drugs be obtained from a participating specialty pharmacy or facility for coverage. Molina Healthcare's specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office. You will be charged a Coinsurance for Specialty Oral and Injectable Drugs.

Stop-Smoking Drugs
Stop-Smoking drugs are prescription drugs within the Molina Healthcare Drug Formulary that we cover to help You stop smoking. You can learn more about Your choices by calling Molina Healthcare's Health Education Department toll-free at 1 (866) 472-9483, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-month supply of stop smoking medication.

Diabetes Supplies
Diabetes supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, , glucagon emergency kits, blood glucose test strips and urine test strips are covered supplies and are provided at Coinsurance Cost Sharing to You. Pen delivery systems for the administration of insulin are also covered and are provided at the Preferred Brand cost share.

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 Authorized.

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."

- Or, 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, provided that 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.

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 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
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Colostomy bags, urinary catheters and supplies.

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, osseointegrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by us.

For internally implanted devices, Inpatient Hospital Services Cost Sharing or Outpatient Hospital/Facility Services Cost Sharing will apply, as applicable.

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 required to hold a prosthesis every 12 months
- 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 are 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

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 Your product:

- Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four hours per visit by 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 the service begins.

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 transportation (ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary.

Non-Emergency Medical Transportation
We cover non-Emergency medical transportation to medical facilities when Your medical and physical condition does not allow You to take regular means of public or private transportation (car, bus, air, etc.). This requires that You also have a written prescription from Your doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. You must have Prior Authorization from Molina Healthcare for these services before the services are given. Please review the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide to determine applicability of this benefit to Your product.

Non-Emergency Non-Medical Transportation
Non-Emergency non-medical transportation is available if You are recovering from serious injury or medical procedure that prevents You from driving to a medical appointment. You must have no other form of transportation available. Your physician (PCP or Specialist Physician) confirms that You require non-Emergency non-medical transportation to and from an appointment on a specified date.

Non-Emergency non-medical transportation for Members to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Call at least two to three working days before Your appointment to arrange this transportation.

If You need non-Emergency non-medical transportation, please call Your PCP or Molina Healthcare's Customer Support Center to see if You qualify for these services. You must have approval to get these services before the services are given. Please review the Molina Healthcare of New Mexico, Inc. Benefits and Coverage Guide to determine applicability of this benefit to Your product.

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

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.
- A Participating Provider physician provides a written Referral for care at the Health Care Facility

CHIROPRACTIC SERVICES

We cover chiropractic diagnostic and treatment services when furnished by licensed Participating Providers and appropriate for the treatment of Your conditions. Coverage does not include maintenance therapy such as routine adjustments. 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. Coverage for acupuncture services is limited to 20 visits in each calendar year, unless for habilitative or rehabilitative purposes. 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 need Urgent Care Services while traveling outside the United States or outside the Service Area, go to Your nearest urgent care center or emergency room. If You require 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 90802

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. Because these services are performed by a Non-Participating Provider You will only be reimbursed for the allowed amount, which may be less than the amount You were charged by the Non-Participating Provider. 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.

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.

Disposable Supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, 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.

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.

Hair Loss or Growth Treatment

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, for example:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching 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 the purpose of 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 that 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

Except as otherwise provided in this EOC, services that are performed by people who do not require licenses or certificates by the state to provide health care services are not covered.

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. For example, if You have a non-covered 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.

Transgender Surgery

We do not cover services and procedures for sexual transformation, including transsexual surgery or hormonal therapy in preparation for, or subsequent to, any such surgery.

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 National Relay Service.

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 on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

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

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 than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

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.

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

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

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

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

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

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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, provided that 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 which 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 Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage 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 Healthcare.

When Will My Molina Healthcare Membership End? (Termination of Benefits and Coverage)

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, 2015, Your last minute of coverage was at 11:59 p.m. on June 30, 2015). 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 deception 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 age or other

eligibility requirements for coverage under this product as required by Molina Healthcare or the Marketplace. You no longer live in Molina Healthcare's Service Area for this product. 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.

- **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.

- **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 and termination will be effective upon 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 omissions, misrepresentations or inaccuracies in Your application form (whether willful or not).

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. Molina Healthcare will offer You a similar product, if available.

- **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 Benefits and Coverage will terminate if Your eligibility for such benefits end. If only certain Benefits 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 month 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:

- 30-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit; 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 month prior to the beginning 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 for Nonpayment of Premiums

- When You have been terminated for nonpayment of Premiums, You may not enroll in Molina Healthcare even after paying all amounts owed unless we approve the enrollment.

- If Molina Healthcare terminates this Agreement for nonpayment of Premiums, we will permit reinstatement of this Agreement once during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice, described below. Molina Healthcare will not reinstate this Agreement if You do not obtain reinstatement of Your terminated Agreement within the required 15 days, or if we terminate the Agreement for nonpayment of Premiums more than once in a 12-month period. In either case, You will be ineligible to re-enroll for a period of 12 months from the effective date of termination.

- Upon reinstatement, as permitted above, You and Molina Healthcare will have the same rights under this EOC that we had under this EOC immediately before the due date of the defaulted premium, subject to any provisions attached in connection with the reinstatement. Any premium accepted by Molina Healthcare with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

- Molina Healthcare may reinstate this Agreement after termination without requiring the execution of a new enrollment application or the issuance of a new identification card or any notice to the Subscriber, other than the acceptance of the delinquent payments made in full.

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: www.molinahealthcare.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 providers 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 referral or treatment options or limit the services offered to Members.
- Adequate access to qualified health professionals for the provision of Covered Services near where You work or live in the Molina Healthcare 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 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 toll-free at 1 (888) 295-7651.
- Give information to Your doctor, provider, or Molina Healthcare 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 on 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 National Relay 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, at the front of this EOC.

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. Benefits and Coverage Guide" at the front of this EOC 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 or out of area 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 Molina Healthcare provider (also known as 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 that was approved or does not require approval, Molina Healthcare will pay You back. 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. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on the first page of this EOC.

After we receive Your letter, we will respond to You within 30 days. If Your claim is accepted, we will mail You a check. If not, we will send You a letter telling You why. If You do not agree with this, You may 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.

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 Referral 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 telephonic 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.

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.

HOW TO FILE A GRIEVANCE

If You have either an Administrative Grievance or want to appeal an Adverse Determination made by Molina (in either case, a "Grievance"), You may contact Customer Support Center toll-free at 1 (888) 295-7651 between 8:00 a.m. to 5:00 p.m. MT, 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 or by dialing 711 for the National Relay Service.

You also may file a written Grievance at:

Molina Healthcare of New Mexico, Inc.
8801 Horizon Blvd. NE
Albuquerque, NM 87113

Or

fax: 1 (505) 342-0583

Or

by email www.molinahealthcare.com.

If You need assistance with filing Your Grievance, You can contact Customer Support. Also, the managed health care bureau of the Office of Superintendent of Insurance can assist You. They may be contacted as follows.

Mail: Office of Superintendent of Insurance: ATTN: Managed Health Care Bureau, P.O. Box 1689, Santa Fe, New Mexico 87504-1689; or

Email: mhcb.grievance@state.nm.us; or

<u>Fax</u>: Office of Superintendent of Insurance, ATTN: Managed Health Care Bureau at 1 (505) 827-4734; or

<u>Completed on-line</u>: with a Complaint Form available at: http://www.osi.state.nm.us/managed-healthcare/managed-healthcare-complaint.html

The process for addressing Grievances depends on whether the Grievance relates to an Adverse Determination or an Administrative Grievance. The process for addressing an Adverse Determination Grievance is described immediately below under "Adverse Determination Grievance Process." The process for addressing an Administrative Grievance is set out on page 87 under "INFORMATION ABOUT GRIEVANCE PROCEDURES."

TYPES OF GRIEVANCES

There are two types of grievances. One type of grievance is where You disagree with an adverse determination made by Molina Healthcare. The second type of grievance is where You have an administrative issue.

What Is An Administrative Grievance?

Administrative Grievance means an oral or written complaint submitted by or on behalf of a grievant regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

(1) Administrative practices of the health care insurer that affects the availability, delivery, or quality of healthcare services;
(2) Claims payment, handling or reimbursement for health care services; and
(3) Termination of coverage.

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What Is An Adverse Determination Grievance?

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, including, with respect to group health plans, a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Adverse Determination Grievance means an oral or written complaint submitted by or on behalf of a grievant regarding an adverse determination.

Language Assistance

Culturally and linguistically appropriate manner of notice means:

(1) Notice that meets the following requirements:

(a) The health care insurer must provide oral language services (such as a telephone assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(b) The health care insurer must provide, upon request, a notice in any applicable non-English language;

(c) The health care insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care insurer.

For purposes of this section, the following definitions are applicable:

- **Grievant means any of the following:**
  - **(1) a policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by the health care plan.**
  - **(2) an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan;**
  - **(3) Medicaid recipients enrolled in a health care insurer's Medicaid plan; or**
  - **(4) individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.**
- **Health Benefits Plan means a health plan or policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan.**
- **Health Care Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan or pre-paid dental plan.**
- **Health Care Professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.**
- **Health Care Services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.**
- **Hearing Officer, Independent Co-Hearing Officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings.**

- **Medical Necessity or Medically Necessary means health care services determined by a provider, in consultation with the health care insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.**
- **Provider means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license.**
- **Rescission of Coverage means a cancellation or discontinuance of coverage that has a retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:**
  (1) The cancellation or discontinuance of coverage has only a prospective effect; or
  (2) The cancellation or discontinuance of coverage is effective retroactively o the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
- **Summary of Benefits means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the grievant by the health care insurer or group contract holder.**
- **Termination of Coverage means the cancellation or non-renewal of coverage provided by a health care insurer to a grievant but does not include a voluntary termination of a health benefits plan that does not contain a renewal provision.**
- **Traditional Fee-For-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage grievants to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.**
- **Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical socities, boards and associations, and any applicable clinical review criteria, policies, practice guidelines , or protocols developed by the health care insurer consistent with the federal, national and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.**

Computation of Time: Whenever the state regulations require that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three (3) working days of the date it was mailed.

General Requirements Regarding Grievance Procedures:

A. Written grievance procedures required. Every health care insurer shall establish and maintain separate written procedures to provide for the presentation, review, and resolution of:

(1) Adverse determination grievances; a health care insurer shall establish procedures for both standard and expedited review of adverse determination

grievances that comply with the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.

(2) Administrative grievances; a health care insurer shall establish procedures for reviewing administrative grievances that comply with the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.

(3) If a grievance contains clearly divisible administrative and adverse decision issues, then the health care insurer shall initiate separate complaints for each issue; with an explanation of the insurer's actions contained in one acknowledgement letter.

B. Assistance to Grievants. In those instances where a grievant makes an oral grievance or request for internal review to the health care insurer, or expresses interest in pursuing a written grievance, the health care insurer shall assist the grievant to complete all the forms required to pursue internal review and shall advise the grievant that the managed health care bureau of the insurance division is available for assistance.

C. Retaliatory Action Prohibited. No person shall be subject to retaliatory action by the health care insurer for any reason related to a grievance.

INFORMATION ABOUT GRIEVANCE PROCEDURES:

A. For grievants. A health care insurer shall:

(1) include a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to grievants;

(2) for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;

(3) notify grievants that a representative of the health care insurer and the managed health care bureau of the insurance division are available upon request to assist grievants with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and summary of benefits issued to grievants;

(4) provide a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to a grievant, provider or other interested person;

(5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to a grievant or provider when the health care insurer makes either an adverse determination or adverse administrative decision; the written explanation shall describe how the health care insurer reviews and resolves grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of the health care insurer's consumer assistance office; and

(6) provide consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution;

(7) provide notice to enrollees in a culturally and linguistically appropriate manner as defined in Subsection E of 13.10.17.7 NMAC;

(8) provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;

(9) not reduce or terminate an ongoing course of treatment without first notifying the grievant sufficiently in advance of the reduction or termination to allow the grievant to appeal and obtain a determination on review of the proposed reduction or termination; and

(10) allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

B. For providers. A health care insurer shall inform all providers of the grievance procedures available to grievants and providers acting on behalf of grievants, and shall make all necessary forms available to providers, including consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution.

C. Special needs. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101 et seq., and 13.10.13 NMAC, Managed Health Care, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

CONFIDENTIALITY OF A GRIEVANT'S RECORDS AND MEDICAL INFORMATION:

A. Confidentiality. Health care insurers, the superintendent, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of grievants when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

B. Procedures required. The superintendent and health care insurers shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of grievants submitted as part of any grievance.

RECORD OF GRIEVANCES:

A. Record required. The health care insurer shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the superintendent.

B. Contents. For each grievance received, the grievance register shall:

(1) assign a grievance number;

(2) indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;

(3) state the date, and for an expedited review the time, the grievance was received;

(4) state the name and address of the grievant, if different from the grievant;

(5) identify by name and member number the grievant making the grievance or for whom the grievance was made;

(6) indicate whether the grievant's coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial health care insurer;

(7) identify the health insurance policy number and the group if the policy is a group policy;

(8) identify the individual employee of the health care insurer to whom the grievance was made;

(9) describe the grievance;

(10) for adverse determination grievances, indicate whether the grievance received expedited or standard review;

(11) indicate at what level the grievance was resolved and what the actual outcome was; and

(12) state the date the grievance was resolved and the date the grievant was notified of the outcome.

C. Annual report. Each year, the superintendent shall issue a data call for information based on the grievances received and handled by a health care insurer during the prior calendar year. The data call will be based on the information contained in the grievance register.

D. Retention. The health care insurer shall maintain such records for at least six (6) years.

E. Submittal. The health care insurer shall submit information regarding all grievances involving quality of care issues to the health care insurer's continuous quality improvement committee and to the superintendent and shall document the qualifications and background of the continuous quality improvement committee members.

F. Examination. The health care insurer shall make such record available for examination upon request and provide such documents free of charge to a grievant, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.

PRELIMINARY DETERMINATION. Upon receipt of a grievance, a health care insurer shall first determine the type of grievance at hand.

A. If the grievance seeks review of an adverse determination of a pre- or post- health care service, it is an adverse determination grievance and the health care insurer shall review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.

B. If the grievance is not based on an adverse determination of a pre- or post- health care service, it is an

administrative grievance and the health care insurer shall review the grievance in accordance with its procedures for administrative grievances and the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.13.10.17.13 NMAC - N, 5-3-04; A, 2-1-08

TIMEFRAMES FOR INITIAL DETERMINATIONS:

A. Expedited decision. A health care insurer shall make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. The health care insurer shall make decisions within twenty-four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:

(1) the life or health of a grievant would be jeopardized;

(2) the grievant's ability to regain maximum function would be jeopardized;

(3) the provider reasonably requests an expedited decision;

(4) in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

(5) the medical exigencies of the case require an expedited decision; or

(6) the grievant's claim involves urgent care.

B. Standard decision. A health care insurer shall make all other initial utilization management decisions within five (5) working days. The health care insurer may extend the review period for a maximum of ten (10) working 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 the grievant; and

(3) provides a written progress report and explanation for the delay to the grievant and provider within the original five (5) working day review period.

INITIAL DETERMINATION:

A. Coverage. When considering whether to certify a health care service requested by a provider or grievant, the health care insurer shall determine whether the requested health care service is covered by the health benefits plan. Before denying a health care service requested by a provider or grievant on grounds of a lack of coverage, the health care insurer shall determine that there is no provision of the health benefits plan under which the requested health care service could be covered. If the health care insurer finds that the requested health care service is not covered by the health benefits plan, the health care insurer need not address the issue of medical necessity.

B. Medical necessity.

(1) If the health care insurer finds that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or grievant, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.

(2) Before a health care insurer denies a health care service requested by a provider or grievant on grounds of a lack of medical necessity, a physician shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer. The physician shall be under the clinical authority of the medical director responsible for health care services provided to grievants.

NOTICE OF INITIAL DETERMINATION:

A. Certification. The health care insurer shall notify the grievant and provider of the certification by written or electronic communication within two (2) working days of the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.

B. 24-hour notice of adverse determination; explanatory contents. The health care insurer shall notify a grievant and provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than twenty-four (24) hours after making the adverse determination, unless the grievant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If the grievant fails to

provide such information, he or she must be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Additionally, the health care insurer shall notify the covered person and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice.

C. Contents of notice of adverse determination.

(1) if the adverse determination is based on a lack of medical necessity, clearly and completely explain why the requested health care service is not medically necessary; a statement that the health care service is not medically necessary will not be sufficient;

(2) if the adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(3) the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(4) include a description of the health care insurer standard that was used in denying the claim;

(5) provide a summary of the discussion which triggered the final determination;

(6) advise the grievant that he or she may request internal or external review of the health care insurer's adverse determination; and

(7) describe the procedures and provide all necessary forms to the grievant for requesting internal appeals and external reviews.

RIGHTS REGARDING INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to internal review. Every grievant who is dissatisfied with an adverse determination shall have the right to request internal review of the adverse determination by the health care insurer.

B. Acknowledgement of request. Upon receipt of a request for internal review of an adverse determination, the health care insurer shall date and time stamp the request and, within one (1) working day from receipt, send the grievant an acknowledgment that the request has been received. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the grievance.

C. Full and fair hearing. To ensure that a grievant receives a full and fair internal review, the healthcare insurer must, in addition to allowing the grievant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide the grievant, free of charge, with any new or additional evidence, and new or additional rationale, considered, relied upon, or generated by the health care insurer, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination to allow the grievant a reasonable opportunity to respond before the final internal adverse benefit determination is made.

D. Conflict of interest. The health care insurer must ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

TIMEFRAMES FOR INTERNAL REVIEW OF ADVERSE DETERMINATIONS: Upon receipt of a request for internal review of an adverse determination, the health care insurer shall conduct either a standard or expedited review, as appropriate.

A. Expedited review. A health care insurer shall complete its internal review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours from the time the internal review request was received whenever:

(1) the life or health of a grievant would be jeopardized;

(2) the grievant's ability to regain maximum function would be jeopardized;

(3) the provider reasonably requests an expedited decision;

(4) in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

(5) the medical exigencies of the case require an expedited decision.

B. Standard review. A health care insurer shall complete a standard review of both internal reviews as described in 13.10.17.19 NMAC and 13.10.17.20 NMAC within twenty (20) working days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within forty (40) working days of receipt of the request in all post-service requests for internal review. The health care insurer may extend the review period for a maximum of ten (10) working days in pre-service cases, and twenty (20) working days for post-service cases 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 the grievant; and

(3) provides a written progress report and explanation for the delay to the grievant and provider within the original thirty (30) day for pre-service or sixty (60) day for post-service review period;

(4) if the grievance contains clearly divisible administrative and adverse decision issues, then the health care insurer shall initiate separate complaints for each decision.

C. Failure to comply with deadline. If the health care insurer fails to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless the grievant, after being fully informed of his or her rights, has agreed in writing to extend the deadline.

FIRST AND SECOND INTERNAL REVIEW OF ADVERSE DETERMINATIONS FOR GROUP HEALTH PLANS:

A. Applicability. This section applies only to health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act that conduct the first level of the internal appeal, and health care insurers who offer group health care benefits plans that conduct the second level of the internal appeal.

B. Scope of review. Health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete the review of the adverse determination within the timeframes established in 13.10.17.18 NMAC.

(1) Coverage. If the initial adverse determination was based on a lack of coverage, the health care insurer shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) Medical necessity. If the initial adverse determination was based on a lack of medical necessity, the health care insurer shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

C. Decision to reverse. If the health care insurer reverses the initial adverse determination and certifies the requested health care service, the health care insurer shall notify the grievant and provider as required by 13.10.17.16 NMAC.

D. Decision to uphold. If the health care insurer upholds the initial adverse determination to deny the requested health care service, the health care insurer shall notify the grievant and provider as required by 13.10.17.16 NMAC and shall ascertain whether the grievant wishes to pursue the grievance.

(1) If the grievant does not wish to pursue the grievance, the health care insurer shall mail written notification of health care insurer's decision, and confirmation of the grievant's decision not to pursue the matter further, to the grievant within three (3) working days of the health care insurer's decision.

(2) If the health care insurer is unable to contact the grievant by telephone within seventy-two (72) hours of making the decision to uphold the determination, the health care insurer shall notify the grievant by mail of the health care insurer's decision and shall include in the notification a self-addressed stamped response form which asks the grievant whether he or she wishes to pursue the grievance further and provides a box for checking "yes" and a box for checking "no." If the grievant does not return the response form within ten (10) working days, the health care insurer shall again contact the grievant by telephone.

(3) If the grievant responds affirmatively to the telephone inquiry or by response form, the health care insurer will select a medical panel to further review the adverse determination as described in 13.10.17.20 NMAC.

(4) If the grievant does not respond to the health care insurer's telephone inquiries or return the response form, the health care insurer shall select a medical panel to further review the adverse

determination when the review is an expedited review.

E. Extending the timeframe for standard review. If the grievant does not make an immediate decision to pursue the grievance, or the grievant has requested additional time to supply supporting documents or information, or postponement pursuant to Subsection G of 13.10.17.20 NMAC, the timeframe described in Subsection B of 13.10.17.18 NMAC shall be extended to include the additional time required by the grievant.

INTERNAL PANEL REVIEW OF ADVERSE DETERMINATIONS:

A. Selection of an internal review panel. In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, the issuer shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

B. Notice of review. Unless the grievant chooses not to pursue the grievance, the health care insurer shall notify the grievant of the date, time, and place of the internal panel review. The notice shall advise the grievant of the rights specified in Subsection G of this section. If the health care insurer indicates that it will have an attorney represent its interests, the notice shall advise the grievant that an attorney will represent the health care insurer and that the grievant may wish to obtain legal representation of their own.

C. Panel membership. The health care insurer shall select one or more representatives of the health care insurer and one or more health care or other professionals who have not been previously involved in the adverse determination being reviewed to serve on the internal review panel. At least one of the health care professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by the grievant and the health care insurer.

D. Scope of review.

(1) Coverage. The internal review panel shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) Medical necessity. The internal review panel shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

E. Information to grievant. No fewer than three (3) working days prior to the internal panel review, the health care insurer shall provide to the grievant copies of:

(1) the grievant's pertinent medical records;

(2) the treating provider's recommendation;

(3) the grievant's health benefits plan;

(4) the health care insurer's notice of adverse determination;

(5) uniform standards relevant to the grievant's medical condition that is used by the internal panel in reviewing the adverse determination;

(6) questions sent to or reports received from any medical consultants retained by the health care insurer; and

(7) all other evidence or documentation relevant to reviewing the adverse determination.

F. Request for postponement. The health care insurer shall not unreasonably deny a request for postponement of the internal panel review made by the grievant. The timeframes for internal panel review shall be extended during the period of any postponement.

G. Rights of grievant. A grievant has the right to:

(1) attend and participate in the internal panel review;

(2) present his or her case to the internal panel;

(3) submit supporting material both before and at the internal panel review;

(4) ask questions of any representative of the health care insurer;

(5) ask questions of any health care professionals on the internal panel;

(6) be assisted or represented by a person of her choice, including legal representation; and

(7) hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

H. Timeframe for review; attendance. The internal review panel will complete its review of the adverse determination as required by the medical exigencies of the case and within the timeframes set forth in 13.10.17.18 NMAC. Internal review panel members must be present physically or by video or telephone conferencing to hear the grievance. An internal review panel member who is not present to hear the grievance either physically or by video or telephone conferencing shall not participate in the decision.

ADDITIONAL REQUIREMENTS FOR EXPEDITED INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. In an expedited review, all information required by Subsection D of 13.10.17.20 NMAC shall be transmitted between the health care insurer and the grievant by the most expeditious method available.

B. If an expedited review is conducted during a patient's hospital stay or course of treatment, health care services shall be continued without cost (except for applicable co-payments and deductibles) to the grievant until the health care insurer makes a final decision and notifies the grievant.

C. A health care insurer shall not conduct an expedited review of an adverse determination made after health care services have been provided to a grievant.

NOTICE OF INTERNAL PANEL DECISION:

A. Notice required. Within the time period allotted for completion of its internal review, the health care insurer shall notify the grievant and provider of the internal review panel's decision by telephone within twenty-four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.

B. Contents of notice. The written notice shall contain:

(1) the names, titles, and qualifying credentials of the persons on the internal review panel;

(2) a statement of the internal panel's understanding of the nature of the grievance and all pertinent facts;

(3) a description of the evidence relied on by the internal review panel in reaching its decision;

(4) a clear and complete explanation of the rationale for the internal review panel's decision;

(a) the notice shall identify every provision of the grievant's health benefits plan relevant to the issue of coverage in the case under review, and explain why each provision did or did not support the panel's decision regarding coverage of the requested health care service;

(b) the notice shall cite the uniform standards relevant to the grievant's medical condition and explain whether each supported or did not support the panel's decision regarding the medical necessity of the requested health care service;

(5) notice of the grievant's right to request external review by the superintendent, including the address and telephone number of the managed health care bureau of the insurance division, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review; this notice of the grievant's right to request external review is in addition to the same notice provided the grievant in the summary of benefits and health benefits plan.

EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to external review. Every grievant who is dissatisfied with the results of a medical panel review of an adverse determination by a health care insurer and where applicable, with the results of a grievance review by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, may request external review by the superintendent at no cost to the grievant. There shall be no minimum dollar amount of a claim before a grievant may exercise this right to external review.

B. Exhaustion of internal appeals process. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) the grievant simultaneously requests an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not

cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the health care insurer shall provide the grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Deadline for filing request.

(1) When required by the medical exigencies of the case. If required by the medical exigencies of the case, a grievant or provider may telephonically request an expedited review by calling the managed health care bureau at (505) 827-4601 or 1-855-427-5674.

(2) In all other cases. To initiate an external review, a grievant must file a written request for external review with the superintendent within one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the superintendent for good cause shown. The cost of the external review will be borne by the health care insurer or health care plan. The request shall be:

(a) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, Post Office Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689; or

(b) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(c) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, at (505) 827-4734; or

(d) completed on-line with an Office of the Superintendent of Insurance Complaint Form available at http://www.osi.state.nm.us/managed-healthcare/managed-healthcare-complaint.html.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer or entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act pursuant to Paragraph (5) of Subsection B of 13.10.17.22 NMAC, and shall also file:

(1) a copy of the notice of internal review decision;

(2) a fully executed release form authorizing the superintendent to obtain any necessary medical records from the health care insurer or any other relevant provider; and

(3) if the grievance involves an experimental or investigational treatment

adverse determination, the provider's certification and recommendation as described in Subsection B of 13.10.17.28 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADVERSE DETERMINATION AND COPY TO HEALTH CARE INSURER:

A. Upon receipt of a request for external review, the superintendent shall immediately send:

(1) the grievant an acknowledgment that the request has been received;

(2) the health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall, within five (5) working days for standard review or the time limit set by the superintendent for expedited review, provide to the superintendent and the grievant by any available expeditious method:

(1) the summary of benefits;

(2) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;

(3) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;

(4) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and

(5) any other documents, records, and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

C. If the health care insurer fails to comply with the requirements of Subsection B of this section, the superintendent may reverse the adverse determination.

D. The superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.

TIMEFRAMES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS: The superintendent shall conduct either a standard or expedited external review of the adverse determination, as required by the medical exigencies of the case.

A. Expedited review.

(1) The superintendent shall complete an external review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:

(a) the life or health of a grievant would be jeopardized; or

(b) the grievant's ability to regain maximum function would be jeopardized.

(2) If the superintendent's initial decision is made orally, written notice of the decision must be provided within forty-eight (48) hours of the oral notification.

B. Standard review. The superintendent shall conduct a standard review in all cases not requiring expedited review. Insurance division staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required of the grievant and health care insurer in Subsection B of 13.10.17.24 and Subsection B of 13.10.17.25 NMAC respectively. If a hearing is held in accordance with 13.10.17.30 NMAC, the superintendent shall complete the external review within forty-five (45) working days from receipt of the complete request for external review in compliance with 13.10.17.24 NMAC. The superintendent may extend the external review period for up to an additional ten (10) working days when the superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to the grievant.

CRITERIA FOR INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY

INSURANCE DIVISION STAFF: Upon receipt of the request for external review, insurance division staff shall review the request to determine whether:

A. the grievant has provided the documents required by Subsection B of 13.10.17.24 NMAC;

B. the individual is or was a grievant of the health care insurer at the time the health care service was requested or provided;

C. the grievant has exhausted the health care insurer's internal review procedure and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act; and

D. the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.

ADDITIONAL CRITERIA FOR INITIAL EXTERNAL REVIEW OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT ADVERSE DETERMINATIONS BY INSURANCE DIVISION STAFF: If the request is for external review of an experimental or investigational treatment adverse determination, insurance division staff shall also consider whether:

A. coverage; the recommended or requested health care service:

(1) reasonably appears to be a covered benefit under the grievant's health benefit plan except for the health care insurer's determination that the health care service is experimental or investigational for a particular medical condition; and

(2) is not explicitly listed as an excluded benefit under the grievant's health benefit plan; and

B. medical necessity; the grievant's treating provider has certified that:

(1) standard health care services have not been effective in improving the grievant's condition; or

(2) standard health care services are not medically appropriate for the grievant; or

(3) there is no standard health care service covered by the health care insurer that is as beneficial or more beneficial than the health care service:

(a) recommended by the grievant's treating provider that the treating provider certifies in writing is likely to be more beneficial to the grievant, in the treating provider's opinion, than standard health care services; or

(b) requested by the grievant regarding which the grievant's treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the grievant's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by the grievant is likely to be more beneficial to the grievant than available standard health care services.

INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF:

A. Request incomplete. If the request for external review is incomplete, insurance division staff shall immediately notify the grievant and require the grievant to submit the information required by Subsection B of 13.10.17.25 NMAC within a specified period of time.

B. Request does not meet criteria. If the request for external review does not meet the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request does not meet the criteria for external review and is thereby denied, and that the grievant has the right to request a hearing in the manner provided by NMSA 1978 Sections 59A-4-15 and 59A-4-18 within thirty-three (33) days from the date the notice was mailed.

C. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to NMSA 1978 Section 59A-4-18 and 13.10.17.30 NMAC has been set to determine whether, as a result of the health care insurer's adverse determination, the grievant was deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with NMSA 1978 Section 12-8-10.

D. Notice of hearing. The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be

considered and shall advise the grievant and the health care insurer of the rights specified in Subsection G of 13.10.17.30 NMAC. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer.

HEARING PROCEDURES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Conduct of hearing. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense.

B. Co-hearing officers. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

C. Powers. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:

(1) require the production of additional records, documents, and writings relevant to the subject of the grievance;

(2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and

(3) if the grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

D. Staff participation. Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer and any independent co-hearing officers.

E. Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer, and other witnesses.

F. Hearing recorded. The hearing shall be stenographically recorded at the insurance division's expense.

G. Rights of parties. Both the grievant and the health care insurer have the right to:

(1) attend the hearing; the health care insurer shall designate a person to attend on its behalf and the grievant may designate a person to attend on grievant's behalf if the grievant chooses not to attend personally;

(2) be assisted or represented by an attorney or other person;

(3) call, examine and cross-examine witnesses; and

(4) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to the health care insurer and the MHCB staff.

H. Stipulation. The grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.

INDEPENDENT CO-HEARING OFFICERS (ICOs):

A. Identification of ICOs. The superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as independent co-hearing officers. The superintendent shall select appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews who maintain independence and impartiality of the process.

B. Disclosure of interests. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the grievant or to the health care insurer or providers involved in a particular external review.

C. Compensation of hearing officers and ICOs.

(1) Compensation schedule. The superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health

care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.

(2) Statement of ICO compensation. Upon completion of an external review, the attorney and co-hearing officers shall each complete a statement of ICO compensation form prescribed by the superintendent detailing the amount of time spent participating in the external review and submit it to the superintendent for approval. The superintendent shall send the approved statement of ICO compensation to the grievant's health care insurer.

(3) Direct payment to ICOs. Within thirty (30) days of receipt of the statement of ICO compensation, the grievant's health care insurer shall remit the approved compensation directly to the ICO.

(4) No compensation with early settlement. If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

D. The hearing officer and ICOs must maintain written records for a period of three (3) years and make them available upon request to the state.

SUPERINTENDENT'S DECISION ON EXTERNAL REVIEW OF ADVERSE DETERMINATION:

A. Deliberation. At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any hearing officer may submit a supplementary or dissenting opinion to the recommended decision.

B. Order. Within the time period allotted for external review, the superintendent shall issue an appropriate order. If the order requires action on the part of the health care insurer, the order shall specify the timeframe for compliance.

(1) The order shall be binding on the grievant and the health care insurer and shall state that the grievant and the health care insurer have the right to judicial review pursuant to NMSA 1978 Section 59A-4-20 and that state and federal law may provide other remedies.

(2) Neither the grievant nor the health care insurer may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent's order.

INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Request for internal review of grievance. Any person dissatisfied with a decision, action or inaction of a health care insurer, including termination of coverage, has the right to request internal review of an administrative grievance orally or in writing.

B. Acknowledgement of grievance. Within three (3) working days after receipt of an administrative grievance, the health care insurer shall send the grievant a written acknowledgment that it has received the administrative grievance. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the administrative grievance.

C. Initial review. The health care insurer shall promptly review the administrative grievance. The initial review shall:

(1) be conducted by a health care insurer representative authorized to take corrective action on the administrative grievance; and

(2) allow the grievant to present any information pertinent to the administrative grievance.

INITIAL INTERNAL REVIEW DECISION ON ADMINISTRATIVE GRIEVANCE: The health care insurer shall mail a written decision to the grievant within fifteen (15) working days of receipt of the administrative grievance. The fifteen (15) working day period may be extended when there is a delay in obtaining documents or records necessary for the review of the administrative grievance, provided that the health care insurer notifies the grievant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the health care insurer and the grievant. The written decision shall contain:

A. the name, title, and qualifications of the person conducting the initial review;

B. a statement of the reviewer's understanding of the nature of the administrative grievance and all pertinent facts;

C. a clear and complete explanation of the rationale for the reviewer's decision;

D. identification of the health benefits plan provisions relied upon in reaching the decision;

E. reference to evidence or documentation considered by the reviewer in making the decision;

F. a statement that the initial decision will be binding unless the grievant submits a request for reconsideration within twenty (20) working days of receipt of the initial decision; and

G. a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.

RECONSIDERATION OF INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Committee. Upon receipt of a request for reconsideration, the health care insurer shall appoint a reconsideration committee consisting of one or more employees of the health care insurer who have not participated in the initial decision. The health care insurer may include one or more employees other than the grievant to participate on the reconsideration committee.

B. Hearing. The reconsideration committee shall schedule and hold a hearing within fifteen (15) working days after receipt of a request for reconsideration. The hearing shall be held during regular business hours at a location reasonably accessible to the grievant, and the health care insurer shall offer the grievant the opportunity to communicate with the committee, at the health care insurer's expense, by conference call, video conferencing, or other appropriate technology. The health care insurer shall not unreasonably deny a request for postponement of the hearing made by a grievant.

C. Notice. The health care insurer shall notify the grievant in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise the grievant of the rights specified in Subsection E of this section. If the health care insurer will have an attorney represent its interests, the notice shall advise the grievant that the health care insurer will be represented by an attorney and that the grievant may wish to obtain legal representation of her own.

D. Information to grievant. No fewer than three (3) working days prior to the hearing, the health care insurer shall provide to the grievant all documents and information that the committee will rely on in reviewing the case.

E. Rights of grievant. A grievant has the right to:

(1) attend the reconsideration committee hearing;

(2) present their case to the reconsideration committee;

(3) submit supporting material both before and at the reconsideration committee hearing;

(4) ask questions of any representative of the health care insurer; and

(5) be assisted or represented by a person of their choice.

DECISION OF RECONSIDERATION COMMITTEE: The health care insurer shall mail a written decision to the grievant within seven (7) working days after the reconsideration committee hearing. The written decision shall include:

A. the names, titles, and qualifications of the persons on the reconsideration committee;

B. the reconsideration committee's statement of the issues involved in the administrative grievance;

C. a clear and complete explanation of the rationale for the reconsideration committee's decision;

D. the health benefits plan provision relied on in reaching the decision;

E. references to the evidence or documentation relied on in reaching the decision;

F. a statement that the initial decision will be binding unless the grievant submits a request for external review by the superintendent within twenty (20) working days of receipt of the reconsideration decision; and

G. a description of the procedures and deadlines for requesting external review by the superintendent, including any necessary forms; the notice shall contain the toll-free telephone number and address of the superintendent's office.

EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Right to external review. Every grievant who is dissatisfied with the results of the internal review of an administrative decision shall have the right to request external review by the superintendent.

B. Exhaustion of remedies. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) the grievant simultaneously requests an expedited internal appeal and an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the health care insurer shall provide the grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon grievant receipt of such notice.

FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Deadline for filing request. To initiate an external review, a grievant must file a written request for external review with the superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision. The request shall either be:

(1) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau – External Review Request, Post Office Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-11689;

(2) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(3) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-4734; or

(4) completed on-line using an Office of the Superintendent of Insurance Complaint Form available at http://www.osi.state.nm.us/managed-healthcare/managed-healthcare-complaint.html.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer pursuant to Subsection G of 13.10.17.36 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE AND COPY TO HEALTH CARE INSURER:

A. Upon receipt of a request for external review, the superintendent shall immediately send the:

(1) grievant an acknowledgment that the request has been received;

(2) health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall provide to the superintendent and the grievant by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTENDENT: The superintendent shall review the documents submitted by the health care insurer and the grievant, and may conduct an investigation or inquiry or consult with the grievant, as appropriate. The superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review in compliance with 13.10.17.38 NMAC.

BINDING ARBITRATION

AGREEMENT TO RESOLVE ALL DISPUTES, INCLUDING FUTURE MALPRACTICE CLAIMS BY BINDING ARBITRATION

******Important Information About Your Rights******

Any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this product, which may include but are not limited to claims of malpractice (e.g., in the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the healthcare provider) or claims that the medical services rendered under the product were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, between Member (including any heirs, successors or assigns of the Member) and Molina Healthcare, or any of its parents, subsidiaries, affiliates, successors or assigns shall be submitted to binding arbitration in accordance with applicable state and federal laws, including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, the New Mexico Uniform Arbitration Act, and the Affordable Care Act. Any such dispute will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

Member and Molina Healthcare agree that, by entering into the agreement enrolling Member in the product, Member and Molina Healthcare are each waiving the right to a trial by jury or to participate in a class action. Member and Molina Healthcare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of final and binding arbitration in accordance with the AAA Commercial Arbitration Rules and Mediation Procedures, and administration of the arbitration shall be performed by the AAA or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days from the date the notice of commencement of the arbitration is received, the arbitrator appointment procedures in the AAA Commercial Arbitration

Rules and Mediation Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration in accordance with the New Mexico Uniform Arbitration Act. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a New Mexico state law court, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.

The parties shall divide equally the costs and expenses of the AAA and the arbitrator. In cases of extreme hardship, Molina Healthcare may assume all or part of the Member's share of the fees and expenses of AAA and the arbitrator, provided the Member submits a hardship application to the AAA. The hardship application shall be made in a manner and with the information and any documentation as required by the AAA. The AAA (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

Member acknowledges that care, diagnosis and treatment will be provided whether or not the Member agrees to binding arbitration. Member, or the Member's Spouse or personal representative in the event of death or incapacity, has the right to cancel this agreement to arbitrate by notifying Molina Healthcare in writing within 60 days after Member's enrollment of Member's intent to cancel this arbitration agreement. The filing of a claim in a court within 60 days after the Member's enrollment by the Member will cancel this arbitration agreement without any further action by the Member.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION.

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 that Molina Healthcare is offering 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 or domestic partner from the Subscriber. When such continuation of coverage is made in the name of the Spouse or domestic partner of the Subscriber, such coverage may, at the option of the Spouse or domestic partner, include coverage to Dependent children for whom the Spouse or domestic partner 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.

- 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 which 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, as determined in Molina's sole discretion, 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 and 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 Benefits and Coverage 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 Benefits and Coverage 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 on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation.

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 notifying us of any change in address.

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

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

MATERNITY POSTPARTUM CARE

We cover the following maternity postpartum care services:

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

- 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).

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

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

MATERNITY POSTPARTUM CARE

We cover the following maternity postpartum care services:

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

- 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 believe that you did not receive your maternity postpartum care benefits, you have the right to complain to the New Mexico Superintendent of Insurance. The Superintendent may be contacted at the following address:

Superintendent of Insurance
ATTN: Managed Health Care Bureau
New Mexico Public Regulation Commission
P.O. Box 1269
1120 Paseo de Peralta
Santa Fe, New Mexico 87504-1269
Email: mhcb.grievance@state.nm.us
Fax: (505) 827-4734

HEALTH EDUCATION AND HEALTH MANAGEMENT SERVICES

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 MANAGEMENT

Molina Healthcare offers many programs tools to help keep You and Your family healthy. You may ask for booklets on topics such as:

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

You can also enroll in any of these programs by calling the Molina Healthcare Health Management Department at 1(866) 891-2320, between 9:30 a.m. and 6:30 p.m. (MT), Monday through Friday.

Molina Healthcare's Health Management Department is committed to helping You stay well.
Find out if You are eligible to sign up for one of Our programs. Ask about other services we provide or request information to be mailed to You. The following are a list of programs and services Molina Healthcare has to offer You.

Call toll-free 1 (866) 472-9483 (Monday through Friday, 9:30 a.m. – 6:30 p.m. MT).

Motherhood Matters®

A Prenatal Care Program for Pregnant Women

Pregnancy is an important time in Your life. It can be even more important for Your baby. What You do during Your pregnancy can affect the health and well-being of Your baby – even after birth.

Motherhood Matters® is a program for pregnant women. This program will help women get the education and services they need for a healthy pregnancy. You will be mailed a pregnancy book that You can use as a reference throughout Your pregnancy.
You will be able to talk with Our caring staff about any questions You may have during Your pregnancy. They will teach You what You need to do. If any problems are found, a nurse will work closely with You and Your doctor to help You. Being a part of this program and following the guidelines will help You have a healthy pregnancy and a healthy baby.

Your Baby's Good Health Begins When You Are Pregnant
You Learn:

- Why visits to Your doctor are so important.
- How You can feel better during Your pregnancy.
- What foods are best to eat.
- What kinds of things to avoid.
- Why You should stay in touch with Molina Healthcare's staff.
- When You need to call the doctor right away.

Other benefits include

- Health Education Materials – These include a pregnancy book and trimester specific materials.
- Referrals – To community resources available for pregnant women.

HEALTH EDUCATION

Molina's Health Education Department is committed to helping You stay well. Find out if You are eligible to sign up for one of Our programs. Call toll-free **1 (866) 472-9483** between 9:30 a.m. and 6:30 p.m. MT, Monday through Friday. Ask about other services We provide or request information to be mailed to You.

The following are a list of health education programs and services Molina has to offer You.

Smoking Cessation Program
This program offers smoking cessation services to all smokers interested in quitting the habit. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support.
Weight Control Program
This program is for Members who need help controlling their weight.

The weight control program is provided for Members 17 years and older. You will learn about healthy eating and exercise. This program is for Members who are ready to commit to losing weight. Once You have understood and agreed to the program participation criteria, You can enroll in the program.

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 National Relay Service
Health Management	To request any information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes.	1 (866) 472-9483 between 9:30 a.m. and 6:30 p.m. MT
Health Education	To request information on wellness, including smoking cessation and weight management.	1 (866) 472-9483 between 9:30 a.m. and 6:30 p.m. MT
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
Motherhood Matters®	Molina Healthcare offers a special program called Motherhood Matters® to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (877) 665-4628
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**
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)

Out-of-network services

In the event medically necessary covered services are not reasonably available through Participating Providers, You may request Prior Authorization review to determine whether obtaining Covered Services from a Non-Participating Provider would be warranted by Medical Necessity review for the specifically requested medical condition. If Covered Services are not reasonably available by Participating Providers, Molina will evaluate the Medical Necessity of such services requested by Your PCP, Specialist or Other Practitioner, and if warranted provide access to Non-Participating Providers as Covered Services for the specifically requested medical condition up to the lesser of any negotiated rate or the Non-Participating Provider's usual, reasonable and customary fee for such services.

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

Molina Marketplace Pediatric Vision Services Rider No. 2

8801 Horizon Blvd. NE
Albuquerque, NM 87113

This Pediatric Vision Services Rider No. 2 amends and supplements the Molina Healthcare of New Mexico, Inc. Agreement and Individual Evidence of Coverage (also called the "**EOC**" or "**Agreement**") and is issued by Molina Healthcare of New Mexico, Inc. ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") for the product specified as part of the Agreement.

The following provisions of the Agreement are amended as follows:

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

"Outpatient Professional Services (cont'd)	**You Pay**
Pediatric Vision Services (for Members under Age 19 Only)	
Vision Exam (limited to 1 routine eye exam in a 12-month period)	No Charge
Prescription eye glasses • Prescription eye glasses (frames & lenses) (limited to 1 pair of prescription eye glasses in a 12-month period) • Lens tinting if certain medical conditions are present • Polycarbonate lenses if certain medical conditions are present • Lenses to prevent double vision • Minor repairs to eyeglasses	[No Charge]
Contact lenses (original prescription or replacement) only when Prior Authorized for certain medical conditions	[No Charge]
Replacement lenses (for lost, broken or deteriorated eye glasses or contact lenses)	[No Charge]

THE GUIDE ABOVE IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF NEW MEXICO, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE, AS AMENDED BY THIS PEDIATRIC VISION SERVICES RIDER NO. 2, SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS."

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

"**Pediatric Vision Services**

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

- One routine eye exam in a 12-month period

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

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

3. All provisions of the Agreement which are not deleted, modified, supplemented or otherwise amended by this Pediatric Vision Services Rider No. 2 remain in full force and effect.

4. The provisions of the Agreement, together with this Pediatric Vision Services Rider No. 2, any other riders or amendments to the Agreement, and any application(s) submitted to Molina Healthcare and/or the Marketplace to obtain coverage under the Agreement , including the applicable rate sheet for this plan, are incorporated into the Agreement by reference, and constitute the legally binding contract between Molina Healthcare, on the one hand, and Subscriber or Member, on the other.