Your Member Handbook

New Mexico

Turquoise Care (2024-2025)

Such services are funded in part with the State of New Mexico

WelcomeToMolina.com/NM

TURQUOISECARE | MOLINA® HEALTHCARE

Thank you for being a Molina Healthcare member!

At Molina, we believe that every member deserves good quality health care. We are here for **you**. And, as always, we treat you like family.

Would you like a printed handbook? Call Member Services at **(844) 862-4543 (TTY: 711)**. We'll send it to you at no cost.

If you would like this handbook in another language or format, including braille or large print, call Member Services.

The most current version of this handbook is available at MolinaHealthcare.com/NMMedicaidResources.

NOTE: The State of New Mexico Health Care Authority (HCA) may change the benefits described in this handbook. If that happens, we will notify you within 30 calendar days. If you have any problem reading this information or need a copy in a different language or in a different format, please call Member Services at **(844) 862-4543 (TTY: 711)**.

In this handbook, you'll find helpful information about:

Getting started

Health care is a journey, and we're with you every step of the way:

1. Review your Welcome Kit

You should have received your member ID card. Please keep it with you at all times. If you haven't received your ID card yet, visit **MyMolina.com** or call Member Services at **(844) 862-4543 (TTY: 711).**

2. Register for My Molina® member portal

Connect to our secure portal from any device, wherever you are, and manage your health online 24 hours a day, 7 days a week. It is easy to use and lets you take care of your health care online.

With My Molina®, you can:

- Print your member ID card
- Request a replacement member ID card if you have lost yours
- Change your primary care provider
- Check your eligibility
- Update your contact information
- Get reminders for health services that you need

You can also view:

- Your history of services, such as doctor visits
- Info and resources to help you and your family stay healthy
- Services offered for members only

Sign up and log in today!
Just follow these easy steps:

Step 1: Go to MyMolina.com
Step 2: Enter your member ID number, date of birth and zip code
Step 3: Enter your email address
Step 4: Create a password

That's it! Now you're ready to log in and use My Molina!

Forgot your password?
Click on **'Forgot your Password?'** and go through the steps to reset it.

3. Register for the My Molina® mobile app

My Molina® is your personalized member portal on your smartphone. You can connect from any smart device. For help on the go, download the My Molina app at no cost from your smartphone's app store. Just search for **My Molina**.

4. Talk about your health

We'll call you to ask you about your health and any needs you have. It will help us identify how to give you the best care and support. Please let us know if your contact information has changed by visiting **MyMolina.com** or calling Member Services at **(844) 862-4543 (TTY: 711)**.

5. Get to know your primary care provider (PCP)

Your primary care provider is your PCP. They will be your primary provider. To choose or change your PCP, go to **MyMolina.com**, **My Molina® mobile app** or call Member Services at **(844) 862-4543 (TTY: 711)**.

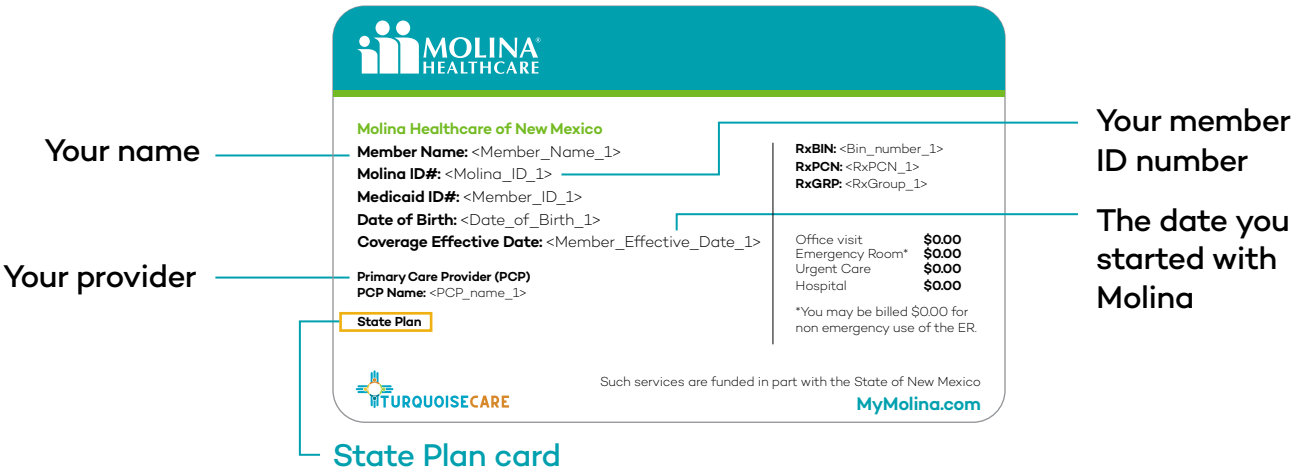
6. Get to know your benefits

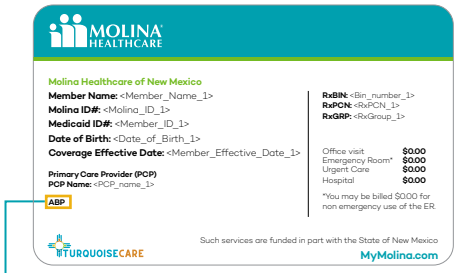
With Molina, you have your Medicaid benefits as well as extra services called value-added services. You also have great rewards for seeing your PCP for your wellness check, getting immunizations and more.

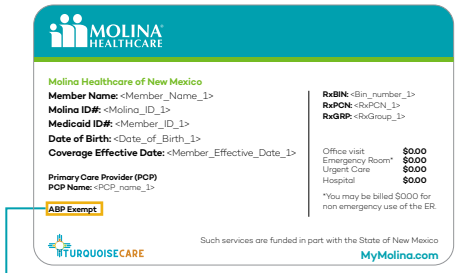
Your membership

Your member ID card

You'll get one ID card for each member of your family.







You need your ID card to:

- See your doctor, specialist and other providers
- Get medical supplies and prescriptions
- Go to a hospital
- Go to an urgent care
- Go to an emergency room
- Have medical tests

Your quick reference guide

Where to go for the information you need

Need	Action
Emergency	**Call 9-1-1**
Online access Molina's Member Portal, **MyMolina.com**, helps you manage your health plan online. You can connect to our secure portal from any device, wherever you are. At **MyMolina.com** you can: • Update your contact information • Request an ID card • And much more	To sign up, visit **MyMolina.com**
Getting care • Urgent care • Minor illnesses • Minor injuries • Physicals and checkups • Preventive care • Immunizations (shots)	**Call your provider** **24-hour Nurse Advice Line** **(833) 965-1558 (TTY: 711)** A nurse is available 24 hours a day, 7 days a week. **Virtual care** at **www.Teladoc.com** **Urgent care centers** Find a provider or urgent care center by visiting MolinaHealthcare.com/NMMedicaidResources
Telehealth services Telehealth is a convenient way to get care for common illnesses without having to go to an in-person office visit, the emergency room or urgent care. For non-emergency issues– including the flu, allergies, rash, upset stomach, and more – you can connect with a doctor through your smartphone or computer to get care wherever you are, whenever you need it. Doctors can diagnose, treat and even prescribe medicine if you need it.	Telehealth is usually done online with internet access on your computer, tablet, or smartphone. Sometimes it can be done over the phone. While telehealth isn't appropriate for every condition or situation, you can often use telehealth to: • Talk to your provider over the phone or through video chat • Send and receive electronic messages with your provider • Participate in remote monitoring so that your provider can track how you're doing at home • Get medically necessary medical and behavioral health care To make a telehealth appointment, visit Teladoc.com.

Need	Action
Your plan details Contact us with questions about your Molina plan. We can help you with questions and help you get the care and services you need.	Member Services **(844) 862-4543 (TTY: 711)** Monday through Friday, 8 a.m. to 5 p.m. (MST) Come see us in Albuquerque, Gallup and Las Cruces. Call Member Services for more information on our walk-in locations. Need to schedule a ride to an appointment? Call Superior Transportation Services at **(833) 707-7100 (TTY: 711)** Monday through Friday, 6 a.m. to 8 p.m. (MST) Or online at: **myride.superior-nm.com/Account/Login**
Update us on changes and life events such as • Other health coverage • Contact information • Marriage • Divorce • Having a baby	Member Services **(844) 862-4543 (TTY: 711)**
New Mexico resources	Children, Youth and Families Department **(855) 333-7233 (TTY: 711)** Social Security Administration **(800) 772-1213 (TTY: 711)** Income Support Division (ISD) **(800) 283-4465 (TTY: 711)** New Mexico Relay Services **TTY: (800) 659-8331** **Voice: (800) 659-1779** **Voice Carryover: (877) 659-4174** Aging & Disabilities Resource Center **(800) 432-2080 (TTY: 711)** Adult Protective Services **(866) 654-3219 (TTY: 711)**

Your provider

Getting care

Your ID Card has the name of a Primary Care Provider (PCP). Your PCP helps coordinate your health care. Your PCP's office is your medical home. If the PCP on your ID Card is not the PCP you and/or your family see, please let us know. It's important to have a provider who makes you feel comfortable. It's easy to choose one with our Provider Directory located here: **MolinaHealthcare.com/NMMedicaidResources**. You can pick a PCP for you and others in your family, or one who sees all of you. You can update your PCP by visiting **MyMolina.com** or by calling Member Services at **(844) 862-4543 (TTY: 711)**. Getting needed care is important. We can also help you make your appointment.

We have a growing family of providers, and they are ready to serve you. Visit providers who are part of Molina. You can find a list of these providers by visiting **MyMolina.com** or on our website: **MolinaHealthcare.com/NMMedicaidResources**. You can also call Member Services and ask for a printed copy.

Schedule your first visit

Visit your provider within 90 days of signing up.

Your provider will:

- Treat you for most of your routine health care needs
- Review your tests and results
- Prescribe medicines
- Refer you to other providers (specialists)

Translation services

If you speak a different language or need something in Braille, large print or audio, don't worry. We will interpret or translate any of our member documents into your preferred language (including sign language). Just contact us and tell us the language you need. We can even arrange to have a translator or sign language interpreter at your appointments. (The interpreter might be on the phone.)

A translator can help you:

- Make an appointment
- Talk with your doctor or nurse
- Get emergency care
- File a grievance or appeal
- Get information about taking medicine
- Follow up about any prior approval you may need for a service
- With sign language

This is a free service. If you need a translator, call Member Services at **(844) 862-4543 (TTY: 711)** Monday-Friday, 8 a.m.-5 p.m. MST.

Network providers

Under your Molina plan, you must get services from network providers. Providers who are not in the Molina provider network are called out-of-network providers, and services from them will not be covered, except in the following cases:

- Urgent care or emergency care
- Family planning services
- Behavioral health emergency services
- Native Americans visiting any Indian Health Service, Tribal 638 Clinic and Urban Indian Health (ITU) providers
- When prior authorization is received from Molina (such as when there are no Molina Network providers that can give you the care you need)

A primary care provider (PCP) can help you and your family stay healthy and provide preventive care. Your PCP will be your main provider. They can help coordinate all your health needs. Every member must have a PCP. You must see a provider who is part of our network. Your specialist may be able to serve as your PCP. To learn more, contact Member Services at **(844) 862-4543 (TTY: 711)**.

If you do not choose a PCP, we will pick one for you. We'll choose a PCP based on your address, preferred language and providers your family has seen in the past.

It is important to know that you have unlimited visits to your PCP. There is no cost to you. Make appointments with them when you feel sick. You should also have a wellness checkup every year to monitor your overall health and develop any necessary prevention plans.

If your PCP leaves the Molina network

If your PCP leaves the Molina network, we will send you a letter letting you know. We will select a new PCP for you. We will send you a new ID card with the name of your new PCP. You can keep the PCP we select or you can call Member Services to pick a PCP of your choice. Call **(844) 862-4543 (TTY: 711)**.

Out-of-network providers

You must use physical and behavioral health providers who work with Molina. We also have hospitals, pharmacies, and dental and vision providers for you to use. If a Molina provider is unavailable to provide covered services, Molina must cover these through an out-of-network provider. This must be done in a timely manner for as long as Molina's network is unable to provide the service. The cost to you should be no greater than it would be if the provider were in-network.

If you have Medicare, your Medicare PCP is not considered out-of-network.

Services from an out-of-network provider must be authorized by Molina except in the situations listed below. If no prior authorization is obtained, services are not covered.

The following services provided by an out-of-network provider do not require prior authorization:

- Emergency care (life-threatening) from a hospital and emergency ambulance
- Urgent care received at an urgent care center
- Family planning such as education and counseling about birth control and pregnancy, lab tests, follow-up care, birth control pills and devices such as IUDs and condoms, tubal ligation and vasectomies
- Native Americans visiting Indian/Tribal/Urban (ITU) providers or Tribal 638 facilities

If your out-of-network service is preauthorized and that provider recommends another out-of-network service, it is your responsibility to make sure you have prior authorization for the new service. If you do not get prior authorization before you receive out-of-network services, you may have to pay the provider. Call Molina for help or prior authorization at **(844) 862-4543 (TTY: 711)**. If Molina provides prior authorization to see an out-of-network provider, you will not have to pay for the service.

Second opinions

A second opinion is when you ask to see another provider about your medical condition. You can get a second opinion from them. You have the right to get a second opinion. If another provider is not available in the network, you may get a second opinion from an out-of-network provider at no cost. If you think you need a second opinion, call Member Services at **(844) 862-4543 (TTY: 711)**.

You might want a second opinion if you:

- Are not sure you need the care
- Are not sure of the doctor's findings
- Have a difficult problem
- Think your doctor is not sure they are giving you the right diagnosis
- Have not improved
- Are not happy with your doctor

How to get specialty care and referrals

Molina offers a network of specialty providers. If you need care that your PCP cannot give you, they will refer you to a specialist. Your PCP is responsible for coordinating these services. Talk with your PCP to be sure you know how referrals work. Getting a referral from your PCP ensures that all your providers know your health care goals and plans. If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see another specialist. It is important you get the care you need. If we do not have a specialist who can give you the care you need, we will get you the care you need from one outside Molina.

There are some treatments and services that your PCP must ask Molina to approve before you can get them. That is called a prior authorization (PA). Your PCP can tell you what services require a PA.

A PA request must be done before any treatments or tests take place. If a request for specialty care is denied, we will contact you and your PCP within one to seven days. You or your PCP can appeal the denial of a prior authorization by calling Molina Member Services at **(844) 862-4543 (TTY: 711)**.

When you may be billed

You may be billed for services not covered by Medicaid. If you see a provider without a referral, or without getting a prior authorization when it is required, you may be billed. Your providers may bill you and/or send you to collections to get the money you owe. You will not lose your Medicaid benefits if you do not pay your bill to a provider for services not covered by Medicaid.

If your bill isn't paid by Molina because your provider did not follow Molina process or procedures, then that provider cannot bill you. If you are being billed by your provider, call Member Services at **(844) 862-4543 (TTY:711)**.

Benefits and services

Emergency medical conditions

An emergency medical condition is a behavioral or physical health condition that is bad enough for an average person to think that without immediate help, there is a serious danger to the health, bodily functions, body parts, organs or appearance of that person or that person's unborn child.

Emergency services

An emergency is a medical or behavioral condition that has symptoms so severe (including severe pain), that if you do not receive care right away, your health might seriously suffer (in the case of a pregnant woman, the health of the unborn child). An emergency might also be when you believe you might ruin a bodily function, lose an organ or lose a body part if you do not get medical attention right away.

Here are some examples of emergencies:

- Heart attack
- Stroke
- Bad chest pain or other pain that does not go away
- Hard time breathing
- Bleeding that does not stop
- Loss of consciousness (passing out)
- Seizures
- Poisoning or drug overdose
- Severe burns
- Serious injury from an accident or fall
- Broken bones
- Injured eye or sudden loss of eyesight
- Feelings of wanting to hurt yourself or others

If you have a medical emergency, you do not need to call Molina before going to the emergency room or calling 911 for emergency ambulance services. In an emergency, you do not have to worry about whether or not the emergency room or ambulance is in the Molina provider network.

What to do in an emergency

Call 911 at once! Go to the closest hospital. Calling 911 will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state.

Tell the hospital that you are a Molina member. Ask them to call Molina at the number on the back of your ID Card.

What is not an emergency

Do not go to an emergency room if you are not having a true emergency. The emergency room is for patients who are very sick or injured and should never be used because it seems easier for you or your family. You may have to wait to be seen for a very long time and the charges for emergency room services are very expensive, even if you have only a small problem.

If you have an illness or health problem, call your PCP first. If you cannot get in touch with your PCP, call the toll-free 24-hour Nurse Advice Line at **(833) 965-1558 (TTY: 711)**. A nurse may suggest that you go to your PCP, an urgent care center or the nearest emergency room. If your PCP's office is closed, the Nurse Advice Line can also help you decide what you should do.

If you know that your illness is not serious or life-threatening and you go to the emergency room or call an ambulance anyway, you may be billed. If you are billed and do not pay your bill, the provider may take legal action against you.

Emergency room and ambulance services

If you have an emergency, you do not need to call Molina before going to the emergency room or calling 911 for emergency services. In an emergency, you do not have to worry about whether the emergency room or ambulance is in the Molina provider network.

Observation stays in the hospital

If you are admitted to the hospital after an emergency room visit, and you only need to stay a short time, your care could be covered as an observation stay instead of an inpatient stay. Your provider will be notified when your illness qualifies as an observation stay.

Follow-up care

After a visit to the emergency room, you may need follow-up care. The health care you receive will either keep your health stable or improve or resolve your health problem. This is called post-stabilization care. This type of care may require prior authorization from Molina. You may receive post-stabilization care in a hospital or other facility. This care is covered.

For other follow-up care, such as medicine refills or having a cast removed, go to your provider's office. For help on how to find post-stabilization providers and get to their locations, call Member Services at **(844) 862-4543 (TTY: 711).**

What is not covered for emergency care

- Follow-up care outside of New Mexico if you could return to New Mexico to receive care without medically harmful results
- Follow-up care received from an out-of-network provider if it is not preauthorized by Molina
- Services received outside the United States

Health care services

We have a growing family of doctors and hospitals. And they are ready to serve you. Visit

providers who are part of Molina. You can find a list of these providers by visiting **MyMolina.com** or on our website at **MolinaHealthcare.com/NMMedicaidResources**. You can also call Member Services at **(844) 862-4543 (TTY: 711)** and ask for a printed copy.

Dental

Healthy teeth and gums are an important part of your overall health.

Molina covers:
- Regular dentist visits
- Checkups
- Cleanings

Yearly visits to the dentist are recommended.

For questions about your dental benefits, please call DentaQuest at **(855) 873-1285 (TTY: 711)**.

You can find dental providers in our Provider Directory: **MolinaHealthcare.com/NMMedicaidResources.**

Vision care

It's important to see your eye care provider regularly to help prevent or reduce vision problems.

Molina covers:
- One exam and one pair of glasses each year for ages 20 and under
- One exam and one pair of glasses every three years for ages 21 and older
- You may also get extra vision benefits using your Molina value added service for vision. See *Value added* services starting on page 33 of this handbook.
- Vision care for eye injury or disease

For questions about your vision benefits, please call March Vision at **(844) 706-2724 (TTY: 711)**.

You can find vision providers in our Provider Directory: **MolinaHealthcare.com/NMMedicaidResources.**

Behavioral health

We can help you get the behavioral health services you and your family need. You must use a provider that is part of our behavioral health network unless it is an emergency. Your inpatient and outpatient services and doctor visits are covered. You may self-refer for behavioral health services. You are not required to visit your PCP first.

Care coordinators can help you get the services you need. They can provide a list of covered services.

What to do if you are having a problem

You might be having any of these feelings:
- Sadness that does not get better

- Feeling hopeless and/or helpless
- Guilt
- Worthlessness
- Difficulty sleeping
- Poor appetite or weight loss
- Loss of interest

If so, call Member Services at **(844) 862-4543 (TTY: 711)**.

Contacting a peer support specialist

We support the use of peer and family support specialists to help with your recovery from mental health or substance abuse issues. Molina can help you get a peer support specialist. Call Member Services at **(844) 862-4543 (TTY: 711)**.

Emergency behavioral health services

A behavioral health emergency is a mental health condition that may cause extreme harm to the body or even death. Some examples of these emergencies are:

- Attempted suicide
- Danger to self or others
- Functional harm where the person is not able to carry out actions of daily life
- Functional harm that will likely cause death or serious harm to the body

If you have an emergency, go to the nearest emergency room, hospital or facility right away. You can also dial the **988 Suicide and Crisis Lifeline**. If you go to the emergency room, let your doctor know about your behavioral health emergency as soon as you can.

If you have a behavioral health emergency and can't get to an approved provider:

- Go to the closest hospital or facility
- Call the number on your ID card
- Call your doctor and follow up within 24 to 48 hours

Mental health and/or substance abuse services

If you need mental health and/or substance abuse services, you may self-refer directly to a provider. You can also call Member Services for help finding a provider and making an appointment. You can find a list of these providers by visiting **MyMolina.com** or on our website: **MolinaHealthcare.com/NMMedicaidResources.** You can also call Member Services at **(844) 862-4543 (TTY: 711)** and ask for a printed copy.

What to do if you have an emergency need for durable medical equipment (DME)?

If you have an emergency need for DME, call your provider. Call 911 if you are in immediate danger. Contact Member Services at **(844) 862-4543 (TTY: 711)** if you cannot get the help you need from your provider.

Long-term services and supports (LTSS)

Long-term services and supports (LTSS) help people with chronic physical and/or behavioral health conditions. When you complete a health risk assessment (HRA), the results of the HRA could show that you may benefit from LTSS. If we see that LTSS can help you, a care coordinator will schedule and complete an in-home comprehensive needs assessment (CNA) with you.

If you do not require 24-hour care, you may be eligible for community benefits. This allows you to stay in your home and supplement the care you get from natural supports. There are two types of community benefits:

- Agency-based
- Self-directed

Agency-Based Community Benefit (ABCB) Long-Term Services and Supports include:

- Adult day health: Day programs in the community where members can enjoy activities such as making art, exercising or visiting with others.
- Assisted living: Residential service in a home-like setting that offers individualized services to meet members' needs.
- Behavior support consultation: Training and supports for individuals who are caring for members with special needs.
- Community transition services: One-time set-up expenses for adults who are going from a nursing facility to a living arrangement in the community where they are responsible for their own living expenses.
- Emergency response services: An electronic device that will help members to get help in an emergency.
- Employment supports: Help members with job training or finding a job.
- Environmental modifications: Changes to member's home to help with safety and independence.
- Home health aide: A trained provider helps members with daily living, including bathing, dressing, cooking and shopping.
- Nutritional counseling: Eating plans and support for health conditions such as diabetes, under-nutriton, cardiovascular health, etc.
- Personal care: Helps the member with activities of daily living including bathing, dressing, cooking and shopping. Members may choose the consumer-delegated or consumer-directed model. A family member may be able to provide this service.
- Private duty nursing for adults: Health-related services provided by an RN or LPN.
- Nursing respite services: Health-related services provided by an RN or LPN that give the main unpaid caregiver a break to reduce stress in case of illness or a family emergency.
- Respite: Gives the main unpaid caregiver a break to reduce stress in case of illness or a family emergency.
- Skilled maintenance therapies: Occupational therapy (OT), physical therapy (PT) and speech and language therapy (SLT) for parents (21 and older).
- If you qualify for Long-Term Services and Supports, you have the option to self-direct your care if you have been receiving Agency-Based Community Benefits for at least 120 days.

SDCB services include:

- Behavior support consultation: Training and supports for individuals who are caring for members with special needs.
- Customized community supports: Day programs in the community where the member can enjoy activities such as making art, exercising or visiting with others.

- Emergency response services: An electronic device that will help the member to get help in an emergency.
- Employment supports: Assists the member with job training or finding a job.
- Environmental modifications: Changes to the member's home to help with safety and independence.
- Home health aide: A trained provider helps members with activities of daily living including bathing, dressing and eating.
- Nutritional counseling: Eating plans and support for health conditions such as diabetes, undernutrition, cardiovascular health, etc.
- Private duty nursing for adults: Health-related services provided by an RN or LPN.
- Related goods: Services, goods and equipment that help members remain in the community.
- Nursing respite services: Health-related services provided by an RN or LPN that give the main unpaid caregiver a break to reduce stress in case of illness or a family emergency.
- Respite: Gives the main unpaid caregiver a break to reduce stress in case of illness or family emergency.
- Self-directed personal care: Helps the member with activities of daily living including bathing, dressing, cooking and shopping. A family member may be able to provide this service.
- Skilled maintenance therapies for adults: Occupational Therapy (OT), Physical Therapy (PT) and Speech and Language Therapy (SLT) for adults (21 and older).
- Specialized therapies: Acupuncture, biofeedback, chiropractic, cognitive rehab therapy, hippotherapy, massage therapy, naprapathy and Native American Healing.
- Transportation (non-medical): Takes the member to and from local community services, activities and resources.

Your care coordinator can tell you more about community benefits. You can reach your care coordinator by calling Member Services at **(844) 862-4543 (TTY: 711)**. You can also contact your care coordinator by visiting **MyMolina.com**.

Hospice care

Hospice is a service to care for those with a terminal illness, with usually six months or less to live. Licensed hospice programs give you and your family support and comfort during the final months of life. If you have questions, please call Member Services at **(844) 862-4543 (TTY: 711)**.

How to access hospital services

Inpatient hospital services

You must have prior authorization (PA) to get hospital services with the exception of emergency or urgent care services. 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 PA.

Medical/surgical services

We cover inpatient services in a Molina provider hospital or rehab facility when the services are usually given by acute care general hospitals or rehab facilities inside our service area:

- Room and board (private room if medically necessary)
- Specialized care and critical care units

- General and special nursing care
- Operating and recovery rooms
- Services of participating providers, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in line with our formulary guidelines (for discharge drugs prescribed when
- released from the hospital, please refer to *Covered drugs* on page 19)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory and special procedures (includes MRI, CT, PET scans and ultrasound imaging)
- Mastectomies (removal of the breast) and lymph node dissections
- Blood, blood products and their administration, blood storage (including the services and supplies of a blood bank)
- Physical, occupational and speech therapy (includes treatment in a rehab program)
- Respiratory therapy
- Medical social services and discharge planning

The provider will file a claim when you get these services. They must do this when Molina is the primary insurance. The provider must send the claim within 90 days from the date you get the service. You must pay your co-pay if one applies. You do not have to pay for the services if you get a referral. You do not have to pay for the services if your provider gets a PA when needed. You do not need to file a claim with Molina. This is the provider's job.

Transportation

Non-Emergency Medical Transportation (NEMT)

Molina works with Superior Medical Transportation to provide transportation to your appointments. You can use this benefit to visit any provider. Medical visits include trips to a doctor, clinic, hospital, therapy or behavioral health services.

Transportation to a pharmacy is not a Turquoise Care covered benefit, but you have it as an extra benefit with us. The transportation benefit may also pay for lodging and food if your care is for a medical or behavioral health visit that is in or out of your home community. Please contact Superior Medical Transportation to see if your trip will meet the requirements for this benefit.

Call Superior Medical Transportation at **(833) 707-7100 (TTY: 711)** Monday-Friday, 6 a.m.-8 p.m. (MST) to schedule your ride. You must call two working days before your visit.

Accompanying Persons or Family Members

Turquoise Care covers one other person to ride with you to your appointments (including that one person's meals and lodging, if applicable) in the following situations:

- You are under the age of 18 and the other person to ride with you is your parent or legal guardian, or
- It is medically necessary for the other person to ride with you. Your medical provider must provide proof of medical necessity in writing. The other person to ride with you must be at least 18 years of age.

With the exception of the previous situations, Turquoise Care does not cover other people riding with you to your appointments. For example, Turquoise Care does not cover minor children riding with you to your appointments.

Emergency Transportation

While the transportation team is talking to you, and if the case sounds like a true emergency, we will tell you to hang up the phone and call 911. We will pay for the ambulance later. Do not call us first if you think your health problem is a true emergency. Please call 911.

To decide if transportation is needed urgently, you may be asked:

- Do you have a fever?
- Are you on oxygen?
- Do you use a wheelchair or walker?
- Are you coughing?

Covered drugs

The Molina Preferred Drug List (PDL) is a list of drugs that are covered under Turquoise Care. The HCA approves the Drug List for all Medicaid managed care plans. You can find the PDL by visiting **MyMolina.com** or on our website: **MolinaHealthcare.com/NMMedicaidResources.** You can also call Member Services at **(844) 862-4543 (TTY: 711)** and ask for a printed copy to be mailed to you.

Mail service pharmacy

Molina wants to offer a time-saving way to get your medicine. You can get a thirty-one (31) day supply on most drugs and up to ninety-three (93) day supply on certain drugs. This is a great benefit. It is easy and can save you time. You don't have to go to the pharmacy every month. If you want more information, call Molina Member Services at **(844) 862-4543 (TTY: 711)**. We can help you sign up.

Specialty pharmacy information

Specialty drugs are used to treat complex conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often need special care. Certain drugs may not be available at every pharmacy. They may only be available through an in-network specialty pharmacy. Please call Molina Member Services at **(844) 862-4543 (TTY: 711)** for assistance.

Molina will usually cover only the drugs on the drug list. The PDL will show whether a brand name or generic version of a drug is preferred. If a generic drug is preferred, the brand name will require approval for medical necessity.

To make sure you do not have any problems filling your prescriptions, always ask your provider to check the PDL. If your provider prescribes a drug that is not on the list or that is not already approved to treat your condition, the provider must have prior authorization from Molina before you can get that medicine. A prior authorization is sometimes called an "exception." Without prior authorization, the pharmacy will not be able to fill your prescription. We will look at your provider's request and supporting information and review for medical necessity.

Requests are generally approved for the following reasons:

- Other drugs on the PDL are not appropriate for your condition.
- A similar drug on the list does not improve your health as much as the drug you are asking for
- A similar drug on the list is harmful to your health

In an emergency, Molina will respond to your provider's request within 24 hours. You may use the appeals process if your request is denied. Note that Native Americans receiving prescriptions from Indian Health Service, Tribal Health Providers and Urban Indian Health providers may receive drugs that are not on the PDL without getting prior authorization from Molina.

There are some drugs we don't cover. These include drugs for:

- Erectile dysfunction
- Weight loss
- Cosmetic purposes
- Infertility

To be sure you are getting the care you need, you and/or your provider can submit a request to us. You and/or your provider will need to explain why you need a certain drug or a certain amount of a drug. We must approve the PA request before you can get the medicine.

Reasons why we may require PA of a drug include:

- The drug can be misused or abused
- The drug is listed in the formulary but not found on the PDL
- There are other drugs that must be tried first

If we do not approve a PA request for a drug, we will send you a letter. The letter will explain how to appeal our decision. It will also detail your rights to a State Fair Hearing. Some drugs may also have quantity or duration limits and some drugs are never covered.

Please contact Member Services at **(844) 862-4543 (TTY: 711)** with any questions you may have. You and/or your provider can also ask for a copy of the prior authorization rules.

Health education and literacy

Molina offers many ways to access information about health promotions, maintenance and prevention for you and your children. This information can teach you about healthy lifestyles and behaviors that may affect your health. Listed below are the ways to get this information. Visit our website at **WelcomeToMolina.com/NM** where you can learn more about:

- Health education classes near you
- How to talk to your provider during your visits
- Programs to help manage your health
- How a disease management program can help you
- Using a virtual visit for non-emergency care

Using your MyMolina.com portal

There are many things you can do on the My Molina member portal, including:

- Read your member newsletter with health and wellness information.
- Sign up for text messages and/or email messages. These can be sent to your cell phone and email. These messages will give you information about your health and wellness, such as reminders about how to manage diabetes, asthma and heart health.

We are here to help you. In addition to the website and **MyMolina.com**, you can call Member Services at **(844) 862-4543 (TTY: 711)**.

Care coordination

Care coordination is a service that provides extra help to members with special health care needs, whether at home, in a skilled facility or in the hospital. Care coordination focuses on you, the member, and when appropriate, your family. It is sensitive to your cultural background. Care coordination can help you better identify your health care needs. It also helps you get appropriate services. This includes coordination of services between doctors in our network as well as out-of-network providers, as appropriate. This includes your medical, behavioral, and long-term needs.

Care coordination includes complex case management and disease management. You may have a chronic condition, such as childhood asthma or adult diabetes, a complex condition or several health conditions, which might include mental health or substance use. Molina care coordinators can work with you and your provider to manage your condition(s).

At a time that can be very stressful, our care coordinators can assist you with understanding your medical condition/ diagnosis and treatment plans, communicating with your providers to coordinate your care, getting the health benefits to which you are entitled and finding health care services based on your condition(s). Your caregiver or your provider can refer you to the program or you can self-refer.

You can end the program at any time. If you have special needs, Molina will assign you a care coordinator who speaks your preferred language and is responsible for coordinating your health care services by:

- Giving you information about providers in our network who may address those needs
- Coordinating medical, behavioral and long-term care services
- Assisting in coordinating care when you also have Medicare or other coverage
- Getting help with different appointments, nonemergency transportation or other needs
- Getting community services not covered by Turquoise Care
- Making sure care coordination is provided when needed

You can reach your care coordinator by calling Member Services at **(844) 862-4543 (TTY: 711)** or by visiting **MyMolina.com**.

Getting help with special health care needs

Some members need extra help with their health care. They may have long-term health problems and need more health care services than most members. They also may have medical, behavioral or long-term care problems that limit their ability to function. We have special programs to help members with special health care needs.

If you believe you or your child has special health care needs, please call Member Services at **(844) 862-4543 (TTY: 711),** and we will connect you to a care coordinator. You can also contact your care coordinator by visiting **MyMolina.com**.

The care coordinator can provide you with a list of resources to help you with your special needs. We also provide education for members with special health care needs and their caregivers. Information is provided about how to deal with stress and/or a chronic illness.

To learn more, call Member Services at **(844) 862-4543 (TTY: 711)**.

What if I am pregnant?

As soon as you think you're pregnant, see your primary care provider (PCP). If you're pregnant, your PCP will want you to see an OB/GYN. This is important. You don't need a referral to see an OB/GYN. If you need help finding one, call Member Services at **(844) 862-4543 (TTY: 711)**.

Molina covers your newborn baby for a period of thirteen (13) months, starting with the month of birth. The hospital or provider should notify HCA of your child's birth to start coverage with Molina. We can also help you notify HCA of the birth by calling Member Services at **(844) 862-4543 (TTY: 711)**.

Family planning services

Family planning or birth control helps you decide when you are ready to have a baby. To get help with your decision, you can see your PCP, any qualified family planning center, or another provider. This includes an OB/GYN provider.

You can get family planning services in- or out-of-network. You can do this without asking your PCP. This includes adolescents. Members have the right to refer themselves to an in-network women's health specialist for routine and preventive health services.

Turquoise Care offers the following family planning and related services to all members. You have the right to receive these services when you need them:

- Family planning counseling and health education, so you will know which birth control method, if any, is best for you
- Lab tests to help you decide which birth control you should use
- Follow-up care for any trouble you may have from using a birth control method that a family planning provider gave you
- Birth control pills
- Pregnancy testing and counseling

Call Member Services at **(844) 862-4543 (TTY: 711)** for more information or for help making appointments.

Birthing options program

You can choose to have a midwife provide you with pregnancy-related services at home or in a birthing center. These services will be covered only if they are provided by health care providers who have an approved provider agreement with HCA. If you are planning to have your baby at home or in a birthing center, you must have prior authorization from Molina. This will help us make sure you are seeing a provider or midwife who can provide such services under the Turquoise Care program.

Call Molina Member Services to learn more about the birthing options program at **(844) 862-4543** (TTY: 711).

If the midwife does not have malpractice insurance, you are assuming all risks of damage and injury.

Home visiting program

Expectant mothers and families with children through age five may qualify to participate in the Medicaid Home Visiting (MHV) program. This program provides services that promote maternal, infant and early childhood health and development.

Home visiting helps families raise happy, healthy children by providing education, support, screenings and resources. Families will learn about pregnancy, child development, parent-child bonding, support services in the community, safety, ways to promote learning through play and everyday interactions and more.

Call Molina Member Services to learn more about the MHV program at **(844) 862-4543 (TTY: 711)**.

Early and periodic screening, diagnostic and treatment (EPSDT)

EPSDT services are provided to every Medicaid-eligible child from birth to age 20. Molina wants your child to be healthy. We will provide well-child checkups and preventive services through your child's regular provider. Your child should have exams at the ages shown on the chart below.

Well-child health check schedule	
Under age 1	3 – 5 days, 1 month, 2 months, 4 months, 6 months and 9 months
Age 1 to 30 months	12 months, 15 months, 18 months, 24 months, and 30 months
Age 3 to 20 years	Each year

Exams may include vaccinations or shots. If your child has not had his or her checkup this year, call their provider and schedule one.

- **Lead testing:** The provider will need to do a blood test to check for lead. Your child should be checked at ages 12 months and 24 months or as soon as possible if they have never been checked.
- **Dental exam:** Your child should have their teeth cleaned and receive fluoride treatments every six months.
- **Private duty nursing:** When your child's provider wants a nurse to provide care at home or at school.
- **Personal care services:** When your child's provider wants a caregiver to help your child with eating, bathing, dressing and toileting.

EPSDT also provides hearing and vision services, school-based services and more. If you have any questions, please contact Member Services at **(844) 862-4543 (TTY: 711)**.

Health problems should be identified and treated as early as possible. If your child needs assistance with daily activities due to a qualifying medical condition, special services like private duty nursing or personal care services will be provided under EPSDT.

Immunizations help keep you well. You and/or your child can receive shots during a PCP visit. Many immunizations are needed before the age of two years. Yearly flu shots are important, too. Ask your PCP which shots you need. Teenage children will also need to receive some shots.

Adult wellness

There are recommended health screenings for both men and women. Women aged 40 through 74 should talk with their provider about having a mammogram every one to two years. Both men and women aged 50 and older should be screened for colon cancer. These are just a few of the necessary screenings. During your PCP visits, talk with the provider about exercise, eating right and safety issues. Your PCP can measure height and weight to ensure you are at a healthy weight.

Services for Native American members

Native Americans can self-refer to Indian Health Services (IHS) or 638 Tribal Healthcare facilities. You can do this for any service. You do not need to ask your PCP. You can also self-refer to any provider in our network. If you are Native American, you do not have any copays. You can use a traditional healing benefit once a year. For more information, call Member Services at **(844) 862-4543 (TTY: 711)**.

Turquoise Care Alternative Benefit Plan Supplement

The Alternative Benefit Plan (ABP) is a part of Turquoise Care. ABP provides medical coverage to adults up to 138% of the Federal Poverty Level (FPL). The benefits, in some cases, are different from Turquoise Care.

ABP recipients will have their medical condition evaluated by Molina. If it is determined that you meet the qualifying conditions, you may choose to become an "ABP Exempt" recipient. If you choose to become ABP Exempt, your coverage will change from the ABP benefit package to the full Medicaid (Turquoise Care) benefit package. Please call Member Services for full details regarding ABP Exempt qualifications.

Some of the services that ABP covers:

- Autism spectrum disorder (benefits provided up to age 22 if enrolled in high school)
- Bariatric surgery (limits apply)
- Behavioral health and substance abuse services
- Cancer trials, chemotherapy, IV infusions and reconstructive surgery
- Cardiac rehabilitation (limited to two consecutive months)
- Chemotherapy
- Dental services (limits apply)
- Diabetes treatment including diabetic shoes
- Dialysis
- Health management
- Durable medical equipment (DME) (limits apply)
- Educational materials and counseling for a healthy lifestyle
- Emergency services (including emergency room visits and psychiatric emergency services)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals aged 19 and 20
- Eye exams (medically necessary and treatment related to treatment and testing of eye diseases)
- Family planning, sterilization and contraceptives
- Genetic testing used to make a diagnosis (limits apply)
- Glasses and contact lenses (limits apply)
- Hearing testing or screening as part of a routine health exam (hearing aids are not covered)

- Home health services (limited to 100 visits per year; one visit may not exceed four hours)
- Hospice services
- Hospital services (inpatient, outpatient, urgent care and emergency room)
- Immunizations and age-appropriate testing such as mammography, colorectal cancer screenings, Pap and PSA tests
- Inhalation therapy
- IV Infusions
- Lab services (diagnostic testing and other age-appropriate tests)
- Mammography, colorectal cancer screenings, pap smears, PSA tests and other age-appropriate tests
- Medical supplies (diabetic and contraceptive supplies)
- Medication-assisted treatment for opioid dependence
- Nutritional counseling (limits apply)
- OB/GYN, prenatal care, deliveries and midwives
- Orthotics (limits apply)
- Physician and most practitioner services and visits (maternity service, surgeries, anesthesia)
- Podiatry (limits apply)
- Prescription drugs (some limits apply)
- Preventive care and annual physicals (see list of preventive services below)
- Prosthetics (limits apply)
- Pulmonary rehab (limited to two months per condition)
- Radiology (diagnostic imaging and radiation therapy, mammograms and other age-appropriate imaging)
- Reconstructive surgery (limits apply)
- Rehab inpatient hospitalization (step-down lower level of care from an acute care hospital before discharge to home)
- Reproductive health services (does not include fertility treatment)
- Skilled nursing (limits apply)
- Sleep studies when necessary to make a diagnosis
- Telemedicine
- Tobacco cessation counseling
- Transplant services (limits apply)
- Transportation services (emergency and nonemergency), including air and ground ambulance
- Urgent care service

Preventive care services:

The following preventive services, as recommended by the United States Preventive Services Task Force (USPSTF), are covered under ABP. Some limits do apply, so please call Member Services for more information.

- Abdominal aortic aneurysm screening (men)
- Alcohol misuse: screening and counseling
- Anemia screening (pregnant women)
- Aspirin to prevent cardiovascular disease (adults)
- Bacteriuria screening (pregnant women)
- Blood pressure screening (adults)
- Breast Cancer Susceptibility Gene (BRCA) screening
- Breast cancer preventive medication
- Breast cancer screening
- Breastfeeding counseling
- Cervical cancer screening

- Chlamydial infection screening (women)
- Cholesterol screening (adults)
- Colorectal cancer screening
- Depression screening (adults)
- Diabetes screening
- Falls prevention for older adults (exercise, physical therapy and vitamin D)
- Folic acid supplementation
- Gonorrhea screening (women)
- Healthy diet counseling
- Hepatitis B screening (pregnant women)
- Hepatitis C virus infection screening (adults)
- HIV screening (non-pregnant teens and adults)
- HIV screening (pregnant women)
- Intimate partner violence screening (women of childbearing age)
- Obesity screening and counseling (adult)
- Osteoporosis screening (women)
- Rh incompatibility screening (first pregnancy visit)
- Rh incompatibility screening (24-28 weeks gestation)
- Sexually transmitted infections counseling
- Skin cancer behavioral counseling
- Syphilis screening (women)
- Tobacco use counseling and interventions (non-pregnant adults)
- Tobacco use counseling (pregnant women)

Services requiring prior authorization

The services listed below require prior authorization:

- Behavioral health (mental health, alcohol and chemical dependency services)
- Bariatric surgery
- CPAP machine
- Cosmetic (plastic and reconstructive procedures)
- Dialysis (notification only)
- Adult diapers and other incontinence products (non-Medicare covered)
- Durable medical equipment, medical supplies, orthotics, prosthetics
- Experimental/investigational procedures
- Genetic counseling and testing
- Home health care (after initial evaluation plus six visits)
- Home infusion
- Outpatient hospice and palliative care (notification only)
- Imaging: CT, MRI, PET, SPECT, cardiac nuclear studies, CT angiograms, intimal medial thickness testing, 3D imaging
- Inpatient admissions: acute hospital, skilled nursing facilities, rehabilitation, long-term acute care facilities, hospice (requires notification only)
- Long-term support services (per state benefit)
- Neuropsychological and psychological testing and therapy
- Non-participating provider/facility services
- Nutritional supplements and enteral formulas
- Occupational therapy after initial evaluation plus six visits
- Outpatient hospital/ambulatory surgery center procedures
- Pain management procedures
- Physical therapy after initial evaluation plus six visits

- Pregnancy and delivery (notification only)
- Rehabilitation: cardiac, pulmonary and Comprehensive Outpatient Rehabilitation Facility (CORF) services (for Medicare only)
- Sleep studies
- Specialty pharmacy drugs (oral and injectable)
- Speech therapy after initial evaluation plus six visits
- Transplant evaluation and services, including solid organ and bone marrow (except cornea transplants)
- Transportation for non-emergent needs via air ambulance or ground ambulance
- Unlisted procedures and wound therapy, including wound vacs and hyperbaric wound therapy

Other services that may be covered under ABP

Here are some services that have limitations on coverage under ABP. Call Member Services to learn more:

- Bariatric surgery
- Cardiac rehabilitation
- Chiropractic services
- Drug items that do not require a prescription (over-the-counter)
- Hearing aids
- Home health care
- Hospice
- Medical foods
- Medical supplies
- Pulmonary rehab
- Rehabilitation and habilitation
- Physical therapy
- Occupational therapy
- Speech and language pathology
- Rehabilitation hospitalization
- Sleep studies
- Transplants

Covered services	Standard Medicaid plan covered service	ABP covered services	Prior authorization (PA) required
Behavioral health: • Mental health • Alcohol and chemical dependency services	✓	✓	Some BH services need prior authorization. PA is not required for services from a community mental health center or a behavioral health services facility.
Cardiology (heart station procedures: Dobutamine Stress Echocardiogram test)	✓	✓	PA is required.
Certified nurse midwife services	✓	✓	PA is not required.

Covered services	Standard Medicaid plan covered service	ABP covered services	Prior authorization (PA) required
Certified nurse practitioner services	✓	✓	PA is not required.
Chiropractic (back) services	✓	✓	PA is required.
Dental services	✓	Limits apply	Routine services do not require PA. Non-routine dental services require PA.
Developmental therapy services for children from birth to six years	✓	✓	PA is required for developmental therapy service after the initial evaluation. Dates of service per 12 months for any combination of services are covered.
Diagnostic services (x-ray, lab)	✓	✓	Some diagnostic services (CT scans, MRIs, MRAs, PET scans, and SPECT) require PA.
Durable medical equipment	✓	Limits apply	Some durable medical equipment items require PA.
Emergency ambulance transportation	✓	✓	PA is not required.
Emergency services (including emergency behavioral health services)	✓	✓	PA is not required.
Family planning services and supplies	✓	✓	PA is not required.
Federally Qualified Health Center or Rural Health Clinic services	✓	✓	PA is not required.
Free-standing birth center	✓	✓	PA is not required. Members should call member services to see if there are any qualified centers in New Mexico.
Home health services	✓	Limits apply	Home health services require PA.
Hospice care (care for terminally ill, e.g., cancer patients)	✓	✓	PA is not required.

Covered services	Standard Medicaid plan covered service	ABP covered services	Prior authorization (PA) required
Inpatient hospital services	✓	✓	Inpatient hospital services require PA. This excludes elective admissions, including pregnancy delivery and all inpatient surgeries. Molina must be notified within 24 hours of admission or by the next business day.
Medical supplies	✓	✓	Some medical supplies require PA.
Nursing facility services for a short-term rehabilitative stay	✓	✓	Nursing facility services require PA. Nursing facility stays are covered for members, unless the New Mexico Health Care Authority's Medical Assistance Division (MAD) determines that the member will return to fee-for-service. Members in need of nursing facility services should call member services for information on available providers.
Obstetrical (maternity care, prenatal and postpartum including at-risk pregnancy services) and gynecological services	✓	✓	PA is not required.
Oral and reconstructive surgery	✓	✓	PA required.
Outpatient hospital services	✓	✓	Some outpatient services require PA.
Pain management services	✓	✓	PA required.
Physical and occupational therapy	✓	✓	PA is required for all occupational and physical therapy services after the initial evaluation is completed. Thirty (30) dates of service per 12-month period for any combination of services are covered
Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source	✓	✓	PA is not required.

Covered services	Standard Medicaid plan covered service	ABP covered services	Prior authorization (PA) required
Podiatry (foot) services	✓	Limits apply	Office visits for examination and plan of care do not require PA. In-office podiatry procedures and interventions require PA.
Prescription drugs, including certain prescribed over-the-counter drugs.	✓	Some limits apply	Selected drugs require PA. This includes injectables and some over-the-counter drugs.
Preventive mammogram (breast) and cervical cancer (pap smear) exams	✓	✓	PA is not required.
Primary care practitioner services	✓	✓	PA is not required.
Renal dialysis (kidney disease)	✓	✓	PA is not required.
Respite services	✓	✓	Respite services require PA. Respite services offer short-term, temporary relief to the informal, primary caregiver of a Supplemental Security Income (SSI) member under the age of 21 in order to support and preserve the primary caregiving relationship.
Screening and counseling for obesity	✓	✓	PA is not required. Screening and counseling for obesity requires a referral by a provider.
Services for children with medical disabilities (Title V)	✓	✓	PA is not required.
Shots (immunizations)	✓	✓	PA is not required.
Specialist services	✓	✓	Office visits to see a specialist do not require PA. Some specialist services do require PA.

Covered services	Standard Medicaid plan covered service	ABP covered services	Prior authorization (PA) required
Speech and hearing services, including hearing aids	✓	✓	PA is required for all speech therapy services after the initial evaluation is completed. Thirty (30) dates of service per 12-month period for any combination of Speech, Language, Pathology and Audiology services are covered. Hearing aids require PA.
Vision (optical) services, including eyeglasses	✓	✓	PA is not required.
Well-child (health check) exams for children under the age of 21	✓	✓	PA is not required.
Yearly well-adult exams	✓	✓	PA is not required.

Services not covered

Non-covered medical services for Turquoise Care participants are:

- Abdominoplasty
- Acupuncture, massage therapists, hypnotherapy, rolfing, biofeedback or chiropractic services (Note: Your Molina Value Added Services may provide you with these services)
- Blepharoplasty (unless necessary to restore unobstructed vision)
- Brow lift
- Calf implants
- Cheek implants
- Chin or nose implants
- Cosmetic services, including plastic surgery, wigs, hairpieces or medications for hair loss
- Duplicate equipment, except for backup ventilator
- External penile prosthesis (vacuum erection devices)
- Facelift (rhytidectomy)
- Facial bone reconstruction sculpturing/reduction, including jaw shortening, forehead lift or contouring
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty)
- Infertility services and treatments
- Laryngoplasty
- Lip reduction or lip enhancement
- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips and thighs reduction
- Medical services provided to a person who is an inmate of a public institution for more than 30 days
- Neck tightening
- Panniculectomy (unless necessary to restore appropriate hygiene following significant weight loss)
- Pectoral implants
- Personal care items, like toothbrushes or television sets in hospital rooms

- Private room expenses, unless your medical condition requires isolation and charges are preauthorized by Molina Healthcare
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple)
- Redundant/excessive skin removal
- Reproductive services including but not limited to procurement cryopreservation/freezing, storage/banking and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa and testicular tissue
- Reversal of a voluntary sterilization
- Rhinoplasty (nose correction)
- Services received outside the United States, including emergency services
- Skin resurfacing
- Some durable medical equipment and supplies (Turquoise Care suppliers of these services know what is covered by Medicaid and what needs prior authorization)
- Temporomandibular joint or craniomandibular joint treatment
- Testicular expanders
- Voice modification surgery and/or voice (speech) therapy or voice lessons

Your extras

Turquoise Care Rewards program

The Turquoise Care Rewards program is part of New Mexico's Turquoise Care. Turquoise Care Rewards lets you earn points for doing certain healthy things. You can use your reward points to shop for hundreds of fun, healthy items in the Turquoise Care Rewards catalog.

For example, you can earn reward points for:

- Having an annual checkup with your primary care provider (PCP)
- Getting a flu shot
- Completing health screenings, like a mammogram, cervical cancer screening and others
- Keeping up to date on your children's immunizations
- And many more!

Visit **TurquoiseRewards.com** to see all of the eligible activities.

As a Turquoise Care member, you are automatically enrolled in Turquoise Care Rewards! To learn more, or to spend your reward points, visit **TurquoiseRewards.com**. You can also call **(877) 806-8964 TTY: (844) 488-9722** Monday–Friday, 8 a.m.–6 p.m. (MST).

Reward points have no cash value and can only be used to shop for items in the rewards catalog. Exclusions and restrictions apply.

Value-added services (VAS)

Molina also offers extra value-added services (VAS) to their members. In addition to covered services, you may be eligible to get extra VAS as a Molina Medicaid member! These value-added services are provided to help you and your family with your health and wellness. Some of these services are time-limited and may have additional requirements or require approval. VAS may change from year to year.

For questions or to access these services, please call Member Services at **(844) 862-4543 (TTY: 711)**. See the table below for a summary of VAS.

VAS	Description	Member action	Eligible populations	Amount/ Service caps
Enhanced transportation	Financial support for medical and non-medical transportation that is not covered by Medicaid	Complete an HRA and participate in care coordination	All members	Up to $300 per calendar year

VAS	Description	Member action	Eligible populations	Amount/ Service caps
Enhanced overnight lodging	Provides overnight lodging to members and their family who are receiving care more than 150 miles from their residence	Complete an HRA and participate in care coordination	All members	Up to $300 per calendar year
Molina Health in Touch	No-cost smartphone, including unlimited talk, text, and data	Complete an HRA and participate in care coordination	All members	No cost to member
Traditional and holistic healing	Support for members to receive traditional and holistic healing services that are aligned with their culture and traditions. Examples include, but are not limited to: therapeutic massage, acupuncture, traditional ceremonies and services and curanderismo	Complete an HRA and participate in care coordination	All members	Up to $300 per calendar year outpatient benefit, and up to $250 per calendar year inpatient benefit
Women's and infant health supplies	We support women and infant health by supplying various new mother and new baby items. Examples include, but are not limited to: OTC pregnancy tests, feminine hygiene products and new baby items (cradle boards, a choice of any size car seat, travel crib, or stroller)	Complete an HRA and participate in care coordination For new baby items: Complete two or more pre-natal well-check visits and/or two or more well-baby checks	All members For new baby items: All pregnant mothers and new mothers	Up to $500 per calendar year for women's health items as well as new mother and new baby items
Enhanced services for LTSS members	Additional support for LTSS members. Examples include, but are not limited to: home modifications/ environmental modifications; additional respite, remote home-based monitoring, home-maker services, personal care services for newly discharged members in need of short-term assistance and support	Complete an HRA and participate in care coordination	LTSS members	Up to $2000 per calendar year

VAS	Description	Member action	Eligible populations	Amount/ Service caps
Workforce and educational development	Supplemental services and supplies to support member education and workforce opportunities and development. Examples include, but are not limited to: books, tools, technology, uniforms, GED vouchers	Complete an HRA and participate in care coordination	All members	Up to $350 per calendar year
Housing assistance	Housing support, including, but not limited to: rental deposit assistance, pest control, and needed home goods	Complete an HRA and participate in care coordination	Members aged 18 years and older	Up to $1000 per calendar year, per household
BeMe	BeMe Health is a digital behavioral health mobile application that delivers mental health interventions designed specifically for teens	Complete an HRA and participate in care coordination	Members up to age 21	None
Enhanced vision	Financial support for additional vision services, including frames and lenses not covered by Medicaid	Complete a Health Risk Assessment and participate in care Coordination	All members	Up to $300 per calendar year
Enhanced dental	Financial support for enhanced dental services not covered by Medicaid that impact overall health	Complete an HRA and participate in Care coordination	All members	Up to $500 per calendar year
Court record expungement	Financial support towards court filing fees necessary to complete a court record expungement	Complete an HRA and participate in care coordination	All members	Up to $200 lifetime benefit
Activity Bucks	Financial support for fees and related expenses associated with participation in activities such as sports leagues, 4H, marital arts, dance, and cheer. Expenses may include the cost of camps or Travel/Club Teams, uniforms, shoes and travel expenses	Complete an HRA and participate in care coordination	All members	Up to $300 per calendar year

Health & Wellness	Home delivered meals tailored to member's nutrition needs; fresh produce; nutritional counseling & Support	Complete an HRA and participate in Care Coordination	All members	$500 Annual per household

Molina Help Finder

Molina members can use Molina Help Finder to help find necessary community assistance. This online search tool can find resources to meet basic needs like food, housing, transportation, health, job training, child care, education, work, legal assistance and more. Molina Help Finder lets you self-refer or apply for services using your member portal or My Molina® mobile app. Your provider can also refer you to services and follow up to make sure you get the help you need. We offer Molina Help Finder in more than 120 languages to make it easy for you to find the resources that are best for you. With Molina Help Finder, help is just a click away. Visit **MolinaHelpFinder.com** to learn more.

Important information

Children In State Custody (CISC)

All non-Native American CISC members will be automatically enrolled with the HCA designated CISC Managed Care Organization (MCO), Presbyterian Health Plan (PHP). PHP will be the only MCO managing care for non-Native American CISC. The enrollment effective date will be the first day of the month when the child is taken into state custody. Once the member is enrolled and in state custody, they will not be able to select a different MCO. Members who are 14 years or older can participate in their care plan and designate their authorized representative. When the member has left state custody, they will be disenrolled effective the last day of the month.

Molina will ensure covered services are available for Native American CISC members or children in Tribal custody. The enrollment of Native American CISC recipients is voluntary. They may enroll with any MCO or receive services through HCA's fee-for-service Medicaid program.

For all transitions of care of CISC or children in Tribal custody, Molina will work with other MCOs and Tribal protective services in the development of the transition of care plan. Molina will ensure the continuity of care for CISC or children in Tribal custody, by allowing these members to continue receiving services from non-contracted providers, honoring existing service authorizations, and reimbursing non-contracted providers.

Community resources

We are part of your community, and we work hard to help make you healthy. Local resources, health events and community organizations are available to you. They provide great programs and convenient services. Best of all, most of them are free or at low cost to you.

- Call 211. This is a free and confidential service that will help you find local resources. Available 24/7
- New Mexico Aging & Disabilities Resource Center - **(800) 432-2080 (TTY: 711)**
- New Mexico Department of Health - **(833) 796-8773 (TTY: 711)**
- Women, Infant, Children (WIC) - **(866) 867-3124 (TTY: 711)**
- Income Support Division (ISD) - **(800) 283-4465 (TTY: 711)**
- New Mexico Health Care Authority (HCA) - **(800) 283-4465 (TTY: 711)**

Eligibility and enrollment

We want to give you high-quality care. We work together with you and your providers to do this. We look at how we can make our services better. We make sure that you:

- Have access to health care services and doctors
- Are happy with your health care and services
- Have doctors and hospitals that are qualified to give you quality services

- Stay healthy by giving you the tools and education you need
- Get the help you need to get well quickly
- Get the tools, education and services to take care of your chronic conditions

We are accredited by the National Committee for Quality Assurance (NCQA). NCQA is a group that makes sure we improve the health care and services you get. We are committed to taking care of you and your family. If you want to know more about our quality improvement programs, please call us or visit **WelcomeToMolina.com/NM**.

HCA decides eligibility for enrollment in Turquoise Care. All Medicaid clients must enroll in Turquoise Care except Native Americans.

If you move

If you move, you must update your address at **www.yes.state.nm.us** or by phone at **(800) 283-4465**. Please call Member Services at **(844) 862-4543 (TTY: 711)** to update your address as well.

Switching to another Managed Care Organization (MCO) or terminating enrollment

Your enrollment with Molina runs for 12 months. During the first 90 days of enrollment, you have one opportunity to switch to a different MCO. If you choose to switch, you will remain enrolled with that MCO for a 12-month period.

If you ask to switch to another MCO, you can do this at renewal or recertification of your eligibility with the Income Support Division (ISD) office. At any other time, you can switch to another MCO "for cause" as defined by the Health Care Authority (HCA). You must ask for this switch in writing. Make your request to HCA.

Some reasons for switching from or terminating Molina:

- Continuity of care
- Allowing family members to have the same MCO
- Fixing a clerical error that caused you to be enrolled with the wrong MCO
- Traveling a far distance for care
- Problems getting the services you need in the network
- Poor quality of care by providers

You must call or send a written request to HCA to switch from Molina. You can do this by calling the New Mexico Medicaid Call Center at (888) 997-2583 or going to YESNM at www.yes.nm.state.us. HCA will review the request and give you a written response no later than the first day of the second month following the month when you asked for the change. If HCA does not respond in time, the request is approved. For help with the disenrollment process, call Member Services at **(844) 862-4543 (TTY: 711)**. If your request is approved, we will work with you to transfer your care to the new MCO. Send your written request to:

HCA Client Services Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348

Your request must have:

- The name of the MCO you want to switch to
- Your name, Social Security number and member ID number
- Your full mailing address and phone number
- The reason for the change (if it involves a doctor, you need to give the doctor's name and phone number)
- Your signature

HCA will send a letter to you if the MCO switch is denied. The letter will tell you about your right to appeal the decision or to ask for a State Fair Hearing.

Renewing your coverage

You need to renew your eligibility every 12 months. If you have any questions, call Member Services at **(844) 862-4543 (TTY: 711)**. You can also call your local Health Care Authority Income Support Division office.

Losing your coverage

You will no longer be covered if you:

- Lose your Medicaid eligibility
- Give false information on your enrollment form
- Move out of the state

If you lose your Medicaid benefits while you are getting care, we can tell you about other services and programs in your area. These programs may help you keep getting care. If you lose your coverage, call your local Health Care Authority Income Support Division office. They can look at your case.

Remember to visit your local Health Care Authority Income Support Division office when you need to recertify your benefits. If you lose your coverage and receive services, you must pay for those services.

Other insurance coverage

Call Member Services to tell us if you have:

- Medical insurance through your workplace
- Been hurt at work
- A worker's injury claim
- A car accident
- Filed a medical malpractice lawsuit
- A personal injury claim
- Other coverage or insurance

We must have this information. It will help us manage your services right.

Outside New Mexico

If you are outside of New Mexico but within the United States and need emergency services, go to the nearest emergency room. Claims for covered emergency medical/surgical services received outside New Mexico from providers that do not contract as Turquoise Care providers should also

be mailed to Molina. If a provider will not file a claim for you, ask for an itemized bill and complete a claim form the same way you would for services received from any other out-of-network provider. Mail both forms to Molina. If you would like to see an out-of-state provider for non-emergency services, you must first receive prior authorization from Molina. If you do not get prior authorization, the services will not be covered. We are here to help you. Contact Member Services at **(844) 862-4543 (TTY: 711)**.

Duplicate (double) coverage

Turquoise Care does not cover amounts already paid when members have other sources of coverage that are legally liable. These may include private insurance, Medicare, or other public programs. If you have any other health care coverage, you must let us know.

Experimental, investigational or unproven services

Turquoise Care does not cover any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical practice. Standard medical practice means services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated
- Are appropriate for the hospital or other facility in which they are performed
- The physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure
- The service must be medically necessary and not excluded by any other contract exclusion

With one exception, Turquoise Care also does not cover any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical practice that is considered experimental, investigational or unproven. The one exception is for certain services in qualifying cancer trials per HCA rules. In addition, if federal or other government agency approval is required for the use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug or medicine cannot be marketed lawfully without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug or medicine is the subject of ongoing phase I, II, III or IV clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, capability or its capability as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

The guidelines and practices of Medicare, the FDA or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by Molina.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical

and scientific journals; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying mainly the same medical treatment, procedure, device or drug; or the written informed consent used by the treating facility or by another facility studying mainly the same medical treatment, procedure, device or drug. If you disagree with Molina's decision regarding any item or service, you may file an appeal. See Grievances and Appeals on page 43.

No effect on treatment decisions

Benefit decisions by Molina Healthcare (like prior authorizations) are different from treatment decisions by you and your health care providers. At times, providers may use clinical practice guidelines to inform their treatment recommendations. You can request these guidelines by calling Member Services at **(844) 862-4543 (TTY: 711)**. Regardless of any benefit decision, the final decision about your care and treatment is between you and your health care provider.

Utilization management

Prior authorization (PA) is a request for service from your doctor. You do not need it for most medical services, but some services do require it. Molina's medical staff and your doctor review the need for this care before services are given. They make sure it is right for your condition.

For a list of covered services that require PA and those that don't, see the covered services chart on pages 27-31 of this handbook. You can also visit **WelcomeToMolina.com/NM** or call Member Services at **(844) 862-4543 (TTY: 711)**.

Utilization management means we look at medical records, claims and prior authorization requests to make sure services are medically necessary, provided in the right setting and consistent with the condition reported. If this management is done before a service is received, it is part of the "prior authorization" process. If it is done while a service is still being received, it is part of the "concurrent review' process. If it is done after a service is received, it is called a "retrospective review."

Utilization management decisions are based only on the appropriateness of care and service. Molina does not reward providers or persons conducting our programs for denying services and does not offer incentives to program decision-makers that would encourage them to approve fewer services than needed. We want to help you get the care you need in the best way possible. The amount, duration or scope of service will not be denied solely because of your specific condition, diagnosis, or illness. A service must be medically necessary, even if a prior authorization is not required. All services are subject to review. If the service is found not needed, you may have to pay for the service in agreement with state and federal guidelines.

Medically unnecessary services

Turquoise Care does not cover services that are not medically necessary. Medically necessary services are clinical and rehabilitative physical or behavioral health services that are:

- Necessary to prevent, diagnose or treat medical conditions or are needed to enable the patient to attain, maintain or regain functional capacity
- Delivered in the amount, duration, scope and setting that is clinically appropriate to the specific health care needs of the patient
- Provided within professionally accepted standards of practice and national guidelines
- Required to meet the physical, behavioral and long-term needs of the patient and are not primarily for the convenience of the patient, the provider or Molina

Molina determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends or approves a service or supply, does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion.

Cosmetic services

Turquoise Care does not cover cosmetic services, which are defined as services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function. This coverage exclusion does not apply to primary gender reassignment chest and/or genital surgeries or to pharmaceutical gender reassignment services, all of which require prior authorization from Molina.

No legal payment obligation

Turquoise Care does not cover services for which you have no legal obligation to pay or that are at no cost, including:

- Charges made only because benefits are available under this program
- Services for which you have received a discount that you have arranged
- Volunteer services
- Services provided by you or a family member for yourself, or by a person ordinarily residing in your household

Out-of-pocket costs

If you get a bill from a plan provider for approved and covered services, call Member Services. Do not pay the bill until you have talked to us. We will help you.

You may have to pay for services that are not covered. You may also have to pay for services from providers who are not part of our network. You may have to pay for services that you self-refer to that require a prior authorization.

If the services were an emergency, you don't have to pay. If you need help, call Member Services at **(844) 862-4543 (TTY: 711)**.

How we pay providers for your care

We contract with providers in many ways. Some providers are paid each time they see you and for each procedure they perform. Other providers get a flat amount for each month a member is assigned to their care.

Some providers may be offered rewards for offering excellent preventive care and monitoring the use of hospital services. We do not reward providers or employees for denying medical coverage or services. We do not give bonuses to providers to give you less care. For more information about how providers are paid, please call Member Services at **(844) 862-4543 (TTY: 711)**. We cannot provide confidential provider information through Member Services or any other department.

Grievances and appeals

We hope you are happy with the care and services you receive. If you are not, we want you to know you have options. You, or someone you choose to help you, may file an appeal or grievance by phone or in writing. Molina can help you complete forms to file a grievance or an appeal at no charge. If you need help, please call Member Services at **(844) 862-4543 (TTY: 711)**. We have people available to help you Monday-Friday, 8 a.m.-5 p.m. (MST). Translation services are also available if needed. Molina will not treat you differently for filing an appeal or grievance.

Grievances

A grievance is an oral or written statement you can make saying you are unhappy about any part of Molina or its operations that is not related to an "adverse benefit determination" (See Appeals section below). Some examples of grievances are:

- The quality of your care or how you were treated
- Failing to respect your member rights
- You are unhappy with the time it takes for authorization decisions
- You disagree with the decision to extend an appeal timeframe
- You want to request a disenrollment from Molina Healthcare of New Mexico, Inc.
- Any other problems you may have getting health care

How to file a grievance

You may file a grievance at any time. You may choose someone to help you file a grievance. This is called an authorized representative. You must give written consent to allow someone to file a grievance on your behalf.

You can file a grievance in writing or over the phone by calling Member Services at **(844) 862-4543 (TTY: 711)**. You can file in writing using any of the following methods:
Send it via the member portal at MyMolina.com

Mail it to:
Molina Healthcare of New Mexico, Inc.
P.O. Box 182273
Chattanooga, TN 37422

Send by fax: (505) 342-0583

Send by email: MNM.Medicaid.MemberAppealsandGrievances@molinahealthcare.com

What to expect when you file a grievance

You will not be treated differently for filing a grievance. When you file your grievance, we will send you a letter within five (5) business days letting you know we received it. We will let you know in writing our decision about your grievance within 30 calendar days from the day we receive it. If we need additional time to make our decision, a 14 calendar-day extension may be requested. If additional time is needed, we will let you know promptly by phone and follow up in writing within two (2) calendar days explaining why it is in your best interest. You may also request an extension if you need more time to support your grievance.

Appeals

You may request an appeal for Molina to review a decision that we made about a service that was denied, reduced or limited. Some examples of appeals would be:

- Denial in whole or part of a requested service
- Stop a service that was previously approved

A denial is when we do not approve or pay for a service that either you or your doctor asked for. When we deny a service, we will send you a letter telling you why we denied the requested service. This letter is the official notice of our decision and is called an "adverse benefit determination." It will let you know your rights and provide information about how to request an appeal.

How to file an appeal

You must send your appeal within 60 calendar days of the date of Molina's denial letter. You, your authorized representative or a provider on your behalf and with your written consent can appeal the decision. If you need help filing your appeal, you can call Member Services, and we will help you complete the steps for filing an appeal.

You can appeal our decision in writing or over the phone by calling Member Services at **(844) 862-4543 (TTY: 711)**. You can file in writing using any of the following methods:
Send it via the member portal at MyMolina.com

Mail it to:
Molina Healthcare of New Mexico, Inc.
P.O. Box 182273
Chattanooga, TN 37422

Send by fax: (505) 342-0583

Send by email: MNM.Medicaid.MemberAppealsandGrievances@molinahealthcare.com

An appeal form and authorized representative form can be found in your denial letter and online at MolinaHealthcare.com. Molina offers only one (1) level of appeal for members.

What to expect when you file an appeal

You will not be treated differently for filing an appeal. You will receive a letter within five (5) business days letting you know that we received your appeal. You will be notified of our decision within 30 calendar days for a standard appeal. If we need additional time to make our decision, a 14-calendar-day extension may be requested. If additional time is needed, we will let you know promptly by phone and follow up in writing within two (2) calendar days explaining why it is in your best interest. If you disagree with our decision to extend your appeal, you have the right to file a grievance.

If waiting 30 days might harm your health or life, you can ask for a fast (expedited) appeal. We will make a decision within 72 hours or sooner. If your request for an expedited appeal is denied, we will notify you promptly by phone and follow up in writing within two (2) calendar days. We will complete your appeal within the standard 30 calendar days.

If we decide that taking the time for a standard appeal puts your health at serious risk, we will start an expedited appeal on your behalf. We will contact you if we have started the expedited appeal. We will give you an expedited appeal decision within 72 hours.

If Molina fails to resolve your appeal and provide notice within the required timeframe above, then your appeal with Molina is considered to be exhausted, and you may request a State Fair Hearing.

State Fair Hearings

If you are unhappy with our decision about your appeal, you can ask for a State Fair Hearing. You must first complete your appeal with Molina before you ask for a State Fair Hearing. You, your authorized representative or your doctor on your behalf and with your written consent, can request the State Fair Hearing. You must send your request within 90 calendar days from the date on the letter from Molina notifying you of our decision.

You can make a request to the New Mexico Health Care Authority (HCA) for a State Fair Hearing in writing, in person or by phone. If you need help requesting a State Fair Hearing or want to file by phone, you can call HCA Office of Fair Hearings at (505) 476-6213.

To file a State Fair Hearing in writing, please send requests to:

Office of Fair Hearings
P.O. Box 2348
Sante Fe, NM 87504-2348

Or Call:
In Santa Fe: (505) 476-6213
Toll-Free: (800) 432-6217, Option 6
Fax: (505) 476-6215
Email: HSD-FairHearings@state.nm.us

Continuing services during an appeal or State Fair Hearing

You may request a continuation of benefits while your appeal with the Office of Fair Hearings is pending. You may request a continuation of benefits within 10 calendar days from the date we mailed the adverse benefit determination (the effective date of the notice) and all of the following steps were met:

- You filed the request for an appeal within 60 calendar days of receiving the notice from Molina denying your service request
- The appeal or State Fair Hearing request is related to the termination, suspension or reduction of services that were previously authorized for you
- The services were requested by an authorized Molina doctor
- The period covered by the original authorization has not ended

If the above are met and you request a continuation of benefits, your benefits may be continued until one of the following occurs:

- You ask to stop the appeal or State Fair Hearing
- You do not request a Fair Hearing within 10 days from the date of Molina's letter notifying you of our decision
- The authorization for services expires, or service authorization limits are met
- A State Fair Hearing decision is made to deny your request

Note: If you keep getting a service during the appeal process or State Fair Hearing and the appeal is denied, you may have to pay for the services you received.

Ombudsman

What is an Ombudsman?
An ombudsman is a person who can help you and will represent you with issues you may be having with Molina. This person is independent, meaning the ombudsman is a person who works for Molina but is separate from the Turquoise Care Molina health plan.

Roles and responsibilities

- Helps members navigate the health plan
- Works with members to help them understand their rights and responsibilities
- Participates in case discussion
- Makes sure that services do not stop due to disagreements between parties
- Provides another view to ensure the member's needs are met

To contact the ombudsman:

- Call **(844) 862-4543 (TTY: 711)**.

Privacy

Your privacy is important to us. We respect and protect your privacy. We use and share your information to provide you with health benefits. We want to let you know how your information is used or shared:

- 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 share Protected Health Information (PHI) as required by law

The above is only a summary. Our Notice of Privacy Practices gives more information about how we use and share your PHI. You may find our full Notice of Privacy Practices at **WelcomeToMolina.com/NM**.

Member Advisory Board

Our purpose is to improve the lives and well-being of our members. We also want to make a positive impact in the communities we serve. Our mission, vision and values help lead every decision we make. One way to achieve our purpose is through our Member Advisory Board.

The Member Advisory Board is a chance for members and members' representatives to work with providers and health plan staff. Members can share thoughts and ideas on ways to improve the health plan. Meetings take place across the state and online, so it's easy to participate.

The Member Advisory Board meets six times per year. Transportation, mileage and childcare can be reimbursed for Molina members so you can attend.

To learn more, call Member Services at **(844) 862-4543 (TTY: 711)**.

Rights and responsibilities

These rights and responsibilities are posted in doctors' offices. They are also posted at **WelcomeToMolina.com/NM**. You or your legal guardians have a right to get information about:

1. Molina, its policies and procedures about products, services, contracted providers, grievance procedures, benefits provided and your rights and responsibilities.
2. You have a right to be treated with courtesy and kindness and with respect and recognition of your dignity, need, and right to privacy.
3. You or your legal guardians have a right to choose a PCP within the limits of the covered benefits and plan network . You also have the right to refuse care of specific practitioners or to notify the provider if changes need to be made. You or your legal guardians have a right to get information from your providers in terms that you or your legal guardian(s)understand, an explanation of your complete medical condition and recommended treatment, risk(s) of the treatment, expected results, and reasonable medical alternatives, regardless of the health care insurers or Molina's position on treatment options. If you are not able to understand the information, the explanation shall be provided to your next of kin, guardian, agent, or surrogate, if available, and noted on the medical record.
4. You have a right to get health care services in a non-discriminatory fashion.
5. If you do not speak English as your first language, you have the right to get translation services at no cost.
6. If you have a disability, you have the right to get information in an alternative format in compliance with the Americans with Disabilities Act.
7. You or your legal guardians have a right to participate with your health care providers in decision-making in all aspects of your health care, including the development of treatment plans, acceptable treatments and the right to refuse treatment.
8. You or your legal guardians have the right to informed consent.
9. You or your legal guardians have the right to choose a surrogate decision maker to be involved, as appropriate, and to help with care decisions.
10. You or your legal guardians have the right to get a second opinion from another provider when you need more information about a recommended treatment or believe the provider is not authorizing the care requested.
11. You have a right to an open and honest discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
12. You or your legal guardians have a right to voice complaints, grievances, or appeals about Molina, the handling of complaints, or the care provided. You or your legal guardians also have the right to make use of Molina's complaint process and the State Fair Hearing process after exhausting Molina's grievance/appeal process, at no cost, without fear of retaliation.
13. You and your legal guardians have a right to file a complaint or appeal with Molina or the State's Fair Hearing Bureau after exhausting Molina's grievance/appeal process and to get an answer to those complaints or appeals within a reasonable time.
14. You and your legal guardians have a right to choose from among the available providers within the limits of Molina's network and its referral and prior authorization requirements.
15. You and your legal guardians have a right to make your decisions known through advance directives about health care decisions (living wills, right-to-die directives, "Do Not Resuscitate" (DNR) orders) consistent with federal and state laws and regulations.
16. You and your legal guardians have a right to the privacy of medical and financial records kept by Molina and its providers, in accordance with existing law.
17. You and your legal guardians have a right to access your medical records in accordance with the applicable federal and state laws and regulations.
18. You have the opportunity to allow or deny the release of identifiable medical or other information by Molina, except when such release is required by law.

19. You have a right to ask for an amendment to your Protected Health Information (PHI) if the information is believed to be incomplete or wrong.
20. You or your legal guardians have a right to get information about Molina, its health care services, and how to get those services and the network practitioners/providers.
21. You or your legal guardians have a right to be given information about Molina's policies and procedures regarding products, services, providers and appeal procedures. You or your legal guardians also have the right to allow the use of your medical information, access to your medical records and to protect access to your medical information and other information about Molina and the benefits provided.
22. You or your legal guardians have a right to know, upon request, of financial arrangements or provisions between Molina and its providers, which may limit referral or treatment options or limit the services offered.
23. You or your legal guardians have a right to be free from harassment by Molina or its network providers concerning contractual disputes between Molina and providers.
24. You or your legal guardians have a right to available and accessible services, when medically necessary, as determined by the PCP or treating provider in consultation with Molina. These services are available 24 hours per day, 7 days per week for urgent or emergency care services and for other health care services as defined by the contract or evidence of coverage.
25. You have the right to adequate access to qualified health professionals near where you live or work, within the service area of Molina.
26. You have a right to affordable health care, with limits on out-of-pocket expenses, including the right to get care from a non-participating provider and an explanation of your financial responsibility when services are given by a non-participating provider or given without required pre-authorization.
27. You or your legal guardians have a right to prompt notification of termination or changes in benefits, services, or provider network.
28. You have the right to continue an ongoing course of treatment for a period of at least thirty (30) days. This shall apply if your provider leaves the provider network or if a new member's provider is not in the provider network.
29. You have the right to make recommendations about Molina's rights and responsibilities.
30. You have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
31. You and your legal guardians have the right to select an MCO and exercise switch enrollment rights without threats or harassment.
32. You have a right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments, or disorders, including restricted benefits and all requirements that you must follow for prior approval and utilization review.
33. You or your legal guardians have all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after consequences of this decision have been explained in a language you understand.
34. You and your legal guardians have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina's internal review and the right to ask for the HCA's help as applicable.
35. You and your legal guardians have the right to get information, when you ask, that HCA determines is important during your first contact with the MCO. This information can include a request for information about the MCO's structure, operation, and/or practitioners' or senior staff's incentive plans.
36. You or your legal guardian shall be free to exercise your rights, and exercising those rights will not result in your adverse treatment or that of your legal guardian.

Member responsibilities

1. You and your legal guardians have a responsibility to give to the extent possible, information that Molina and its providers need in order to care for you.
2. You and your legal guardians have a responsibility to understand your health problems and to help in developing treatment goals that everyone can agree to.
3. You and your legal guardians have a responsibility to follow the plans and instructions for care that they have agreed on with your provider or to notify providers if changes are requested.
4. You or your legal guardians have a responsibility to keep, reschedule or cancel an appointment rather than simply not show up.
5. You and your legal guardians have a responsibility to look at the Member Handbook and, if there are questions, call Member Services for details on benefits, limits and exclusions. The Member Services telephone number is on your ID card.
6. You and your legal guardians have a responsibility to follow Molina's policies, procedures and instructions for getting services and care.
7. If you or your legal guardian sees a self-referred specialist or provider without following Molina procedures and Molina denies the service, the provider may bill you.
8. You and your legal guardians have a responsibility to show your ID card each time you go for medical care and to tell Molina right away of any loss or theft of your ID card.
9. You or your legal guardians have a responsibility to tell a participating provider of their coverage with Molina at the time of service. You may have to pay for services if you do not tell the participating provider of your coverage.
10. You and your legal guardians have a responsibility to pay for all services you get before the effective date with Molina and after the termination or cancellation of coverage with Molina if you do not have insurance. covered. If you are covered with Fee-for-Service Medicaid, another MCO or another insurance company before the effective date or after termination or cancellation with Molina should tell the provider about your other coverage.
11. You or your legal guardians have a responsibility to tell the ISD Caseworker if there is a change in name, address, telephone number or changes in your family.
12. You and your legal guardians have a responsibility to tell HCA and Molina if you get other medical coverage.
13. You and your legal guardians have a responsibility to pay for all co-pays and/or co-insurance at the time services are rendered.

Advance directives

Your provider has advance directive forms. Please fill out the form to tell your family, providers and those who need to know the care you want during an illness or medical emergency. The form will be put in your medical file. You can end or change the advance directive at any time. You just need to tell us your wishes.

We respect your culture and traditions. We would not place any limits on your advance directive. Sometimes the person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find a provider who will follow your wishes.

If you want to know more about this, call Member Services at **(844) 862-4543 (TTY: 711)**. We will help you.

Psychiatric Advance Directives (PAD)

You have the right to create a Mental Health Care Directive (MHCD) for mental health and substance use issues. This is also known as Psychiatric Advance Directive and allows you to have a written document that tells your health care providers, family members and others what your wishes are if you go into relapse for your behavioral health issues or cannot make decisions for yourself about your care, including refusal for treatment. Your MHCD should be written, signed, and witnessed.

Your MHCD should include:

- A designated person ("agent") to make decisions for you if you are too sick or ill to make decisions for yourself. This is called being "incapacitated."
- A written set of instructions on what you would like to have happen and how or where you would like to be treated if you cannot make decisions for yourself. This could include:
  - Medicines that you do not want to be given or would prefer to be given
  - Places you would like to be taken for treatment or types of treatment
  - Treatment you should or should not be given
  - People who may or may not visit you in treatment

Examples of common types of advance directives include:

A living will or declaration
A living will informs your health care providers and family of the kind of medical care you want or do not want if you cannot make your own decisions. In New Mexico, the Uniform Health Care Decisions Act ensures that an adult of sound mind may execute at any time a statement governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the individual or another person at the individual's direction and witnessed by two adults or a notary.

Treatments could include:

- Feeding tubes
- Breathing machines
- Organ transplants
- Treatments to make you comfortable

If you want to sign a living will, you can:

- Ask your PCP for a living will form.
- Fill out the form by yourself or call us for help.
- Take or mail the completed form to your PCP or specialist. Your PCP or specialist will then know what kind of care you want to get.

A Durable Power of Attorney for Health Care (DPAHC)
This lets you choose someone to make health care decisions for you when you cannot make them yourself. This trusted person follows the instructions you give. The power of attorney must have clear dates for when it starts and ends. It must also be witnessed and signed by two adults or signed and acknowledged for you by a notary.

A Do Not Resuscitate (DNR) order
This tells health care providers not to give you cardiopulmonary resuscitation (CPR) if your heart and/or breathing stops. A DNR order is only about CPR. It does not provide instructions about other treatments.

Ask your provider or contact Member Services to find out more about advance directives.

Fraud, waste and abuse

Our fraud, waste and abuse plan helps Molina, our employees, members, providers, payers and regulators. It increases efficiency, reduces waste and improves the quality of services. We take the prevention, detection and investigation of fraud, waste and abuse seriously.

Molina complies with state and federal laws. We investigate all suspected cases of fraud, waste and abuse. We promptly report them to government agencies. We take the appropriate disciplinary action. This may include termination of employment, provider status and/or membership. You can report fraud, waste and abuse without giving us your name.

To report suspected fraud, call the Molina Healthcare Alert Line at **(866) 606-3889 (TTY: 711).** You can also complete a report form online at **MolinaHealthcare.Alertline.com**.

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for them or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR §455.2)

Waste means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g., coding) causes unnecessary costs to the Medicaid/Medicare.

Abuse happens when provider practices are inconsistent with sound fiscal, business or medical practices. Such practices result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

Here are some ways you can help stop fraud:

- Don't give your Molina ID card, Medical ID card or ID number to anyone other than a provider, a clinic or a hospital and only when receiving care
- Never let anyone borrow your member ID card
- Never sign a blank insurance form
- Be careful about giving out your Social Security number

Definitions

Abuse - Abuse is when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards. Examples of abuse are billing for services that aren't medically necessary, overcharging for services or supplies, and misusing billing codes to increase reimbursement.

Advance Directive – Choices you make about your medical care. A form that tells how you want to be cared for while sick or in an emergency.

Appeal – A formal request for Molina to review an adverse decision or action.

Authorization – An approval for a service.

Benefit period – The period of time you have health insurance.

Covered services – Services and supplies covered by Molina.

Durable Medical Equipment (DME) and Medical Supplies Equipment – This equipment is needed to give mechanical substitution or help to you. It will help prevent worsening of a medical condition. It is not usually useful to a person without illness or injury. DME items include:

- Wheelchairs
- hospital beds
- Oxygen
- Oxygen supplies

This equipment is:

1. Used to serve a medical purpose.
2. Designed for repeated use.

Emergency medical condition – A medical problem you think is so serious that a provider must treat it right away.

Emergency services – Services given by a qualified provider that are needed to evaluate, treat or stabilize an emergency medical condition.

Fraud - Fraud is when someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program. Medicare or Medicaid fraud is considered a criminal act.

Grievance – A complaint about any Molina operations or a care provider.

HIPAA – Refers to the Health Insurance Portability and Accountability Act. A set of rules that helps keep patient health information secure and private.

Health Care Authority (HCA) – The official department in New Mexico in charge of overseeing Medicaid. HCA may also indicate the department's designee (Molina).

I/T/U – Indian Health Service, Tribal Health Providers, Urban Indian Providers.

Medical director – A physician employed by Molina to serve as a medical director of the plan.

Medically necessary – Clinical, rehabilitative, physical or behavioral health services that are:

1. Needed to prevent, diagnose or treat medical conditions
2. Needed to attain, maintain or regain functional capacity
3. Delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the person
4. Provided within professionally accepted standards of practice and national guidelines
5. Required to meet the physical and behavioral health needs of the person and are not primarily for the convenience of the person, the provider or payer

Member – A person who is eligible for Medicaid and who is enrolled with Molina.

Non-covered services (benefits) – Services that are not covered. New Mexico decides this. Molina will not pay for services that are not covered. If you get a non-covered service without Molina's authorization, you will have to pay the bill.

Preventive health care – Health care focused on finding and treating health problems and preventing disease or illness.

Primary care provider (PCP) – A Molina contracted provider that you have chosen to be your provider. Your PCP helps you with most of your medical needs.

Protected health information (PHI) – PHI is your health information. It includes your name, member number or other things that can identify you. PHI is used or shared by Molina.

Prior authorization (PA) – The process for any service that needs approval from Molina before you can get it.

Provider directory – A list of all of the providers contracted with Molina.

Referral – When your PCP sends a request for you to see another provider for care.

Service area – The geographic area where Molina provides services.

Specialist – A provider who focuses on a particular kind of health care.

Urgent care services – Medical health services needed to treat an unforeseen illness or injury. The illness or injury is less serious than an emergency but needs prompt treatment to prevent serious decline in health.

Waste - Waste is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program. Examples of waste are conducting excessive office visits, prescribing more medications than necessary, and ordering excessive laboratory tests.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to **Civil.Rights@MolinaHealthcare.com**.

You can also file your complaint with Molina Healthcare AlertLine, twenty-four hours a day, seven days a week at: **MolinaHealthcare.Alertline.com**.

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

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

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

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

Non-Discrimination Tag Line– Section 1557
Molina Healthcare of New Mexico, Inc.– Medicaid

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (844) 862-4543 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 862-4543 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áka'anída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíilnih (844) 862-4543 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (844) 862-4543 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (844) 862-4543 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (844) 862-4543（TTY：711）。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (844) 862-4543 (رقم هاتف الصم والبكم: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 862-4543 (TTY: 711) 번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (844) 862-4543 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (844) 862-4543 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (844) 862-4543 (TTY : 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (844) 862-4543 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (844) 862-4543 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (844) 862-4543 (TTY: 711) पर कॉल करें।
Persian (Farsi)	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (844) 862-4543 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (844) 862-4543 (TTY: 711).

MOLINA®
HEALTHCARE