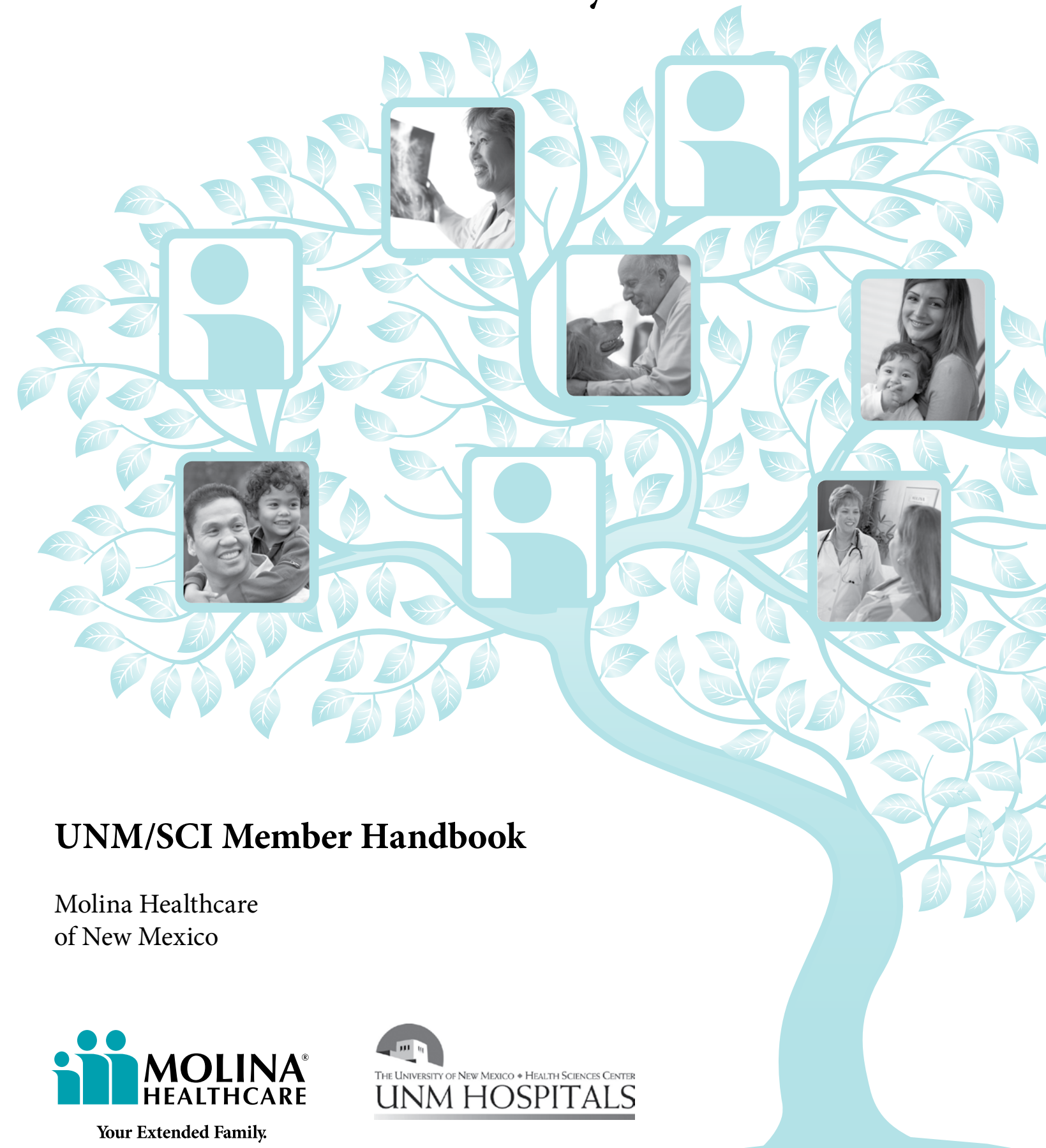


# Welcome to the Molina family.



PO Box 3887  
Albuquerque, NM 87190-9859  
[www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)



## UNM/SCI Member Handbook

Molina Healthcare  
of New Mexico



Your Extended Family.



Part# 5090NM1208  
Services are funded in part under contract with the State of New Mexico

# Important Telephone Numbers and Information

Member Services:	(505) 348-1578 (866) 403-3018 toll free <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a>
UNMH Pharmacy:	(505) 272-2308
Nurse Advice Line:	(877) 725-2552 toll free
NM Relay Services/TTY:	(800) 659-8331 toll free
Health Improvement Hotline:	(505) 342-4660 ext. 182618 (800) 377-9594 ext. 182618 toll free
Anti-Fraud Hotline:	(505) 341-7469 (800) 827-2973 toll free
Complaint, Appeal and Grievance Hotline:	(505) 342-4663 (800) 723-7762 toll free
UNMH Patient Financial Services:	(505) 272-2521
Your Primary Care Practitioner (PCP):	
Your Durable Medical Equipment (DME) Provider:	

[http://hospitals.unm.edu/Healthcare/UNMCare\\_SCI/UNMCareIndex.shtml](http://hospitals.unm.edu/Healthcare/UNMCare_SCI/UNMCareIndex.shtml)

If you have a medical emergency, go to the emergency room or dial 911.

**Call Member Services if you want a copy of this handbook in large print.**

Call Member Services if you want a copy of this handbook in Spanish or Vietnamese.

Para recibir una copia de este manual en español, por favor llame al departamento de servicios al miembro.

Neu quy vi muon co ban tieng Viet cua cuon cam nang nay, xin dien thoai toi Van Phong Dich Vu cho thanh Vien (Member Service Department).

# Welcome

Thank you for choosing the State Coverage Insurance (SCI) University of New Mexico Care Initiative (UNMCI) Program. This program is administered by Molina Healthcare of New Mexico, Inc. (Molina Healthcare).

This Member Handbook helps you learn about Molina Healthcare. It helps you learn about the benefits and services you can get in the SCI/UNMCI Program. Please read your Member Handbook. It will help you know your benefits. Call us if you have questions. Let us know if you need help understanding your Member Handbook.

Your Member Handbook tells you how to use your benefits. It is not a legal document. Please take time to read your Member Handbook. Do not wait until you have an emergency. Keep your Member Handbook where you can find it.

There are some restriction and/or limitations to the SCI/UNMCI Program you should know about. These restrictions and/or limitations are talked about in your Member Handbook.

You should use the University of New Mexico Hospital (UNMH) network of providers unless the practitioner/provider specialty you need is not available within a reasonable timeframe or is not available in the network. If you have an emergency, go to the emergency room. Call Member Services if you have questions. We can help you.

The SCI/UNMCI benefit package is limited to \$100,000 in services. We will tell you when you have used \$85,000 in services.

The SCI/UNMCI benefit package is limited to twenty-five (25) inpatient days. We will tell you when you have used twenty (20) inpatient days.

More information about these restrictions and/or limitations is available in this Member Handbook. Call Member Services if you have questions.

Molina Healthcare wants to help you. Call the Member Services Department if you have questions. You can reach us Monday - Friday (except on holidays). Our hours are between 8:00 a.m. and 5:00 p.m.

- Albuquerque: (505) 348-1578
- Toll free Statewide: (866) 403-3018
- Fax: (505) 342-0595

Molina Healthcare has Member Service Representatives who speak your language. They can help answer your questions. They can help answer questions you have about your SCI/UNMCI Member Handbook. They can help answer questions about other Member materials you may get.

If you have special medical needs, call the Member Services Department. We can help you.

If you are deaf or hard of hearing and you use a TTY system, you can still call Member Services. Molina Healthcare uses the Relay NM Service. First dial (800) 659-8331 toll free using the TTY system. A Relay NM Service operator will come on the line. Give the operator Molina Healthcare's toll free telephone number, (866) 403-3018. The Relay NM Service operator will help you. They will connect you with Member Services.

# Quality Care Services

Molina Healthcare wants to give you high quality care. We work with our practitioners/providers and Members to do this. We look at how we can make our services better. We make sure:

- You have access to health care services and doctors;
- You are happy with your care and services;
- Doctors and hospitals are qualified to give you quality services;
- You stay healthy by giving you the tools and education you need;
- You get the help you need to get well quickly; and
- You get the tools, education and services to take care of your chronic conditions.

Molina Healthcare is approved by the National Committee for Quality Assurance (NCQA). NCQA is a group that makes sure we continue to improve the health care and services you get.

Molina Healthcare is committed to taking care of you. If you want to know more, call our Quality Department in Albuquerque at (505) 342-4660, ext. 182618 or toll free at (800) 377-9594, ext. 182618.

We are happy to help. We are glad you are a Molina Healthcare Member.

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# MEMBER SERVICES

## What can Member Services do for you?

Member Services can answer your questions. We are here to help you.

You can write to Member Services at:

Molina Healthcare  
Attention: Member Services  
P.O. Box 3887  
Albuquerque, NM 87190-9859

You can call Member Services at:

In Albuquerque: (505) 348-1578  
Toll free statewide: (866) 403-3018

## Translation or TTY Services

If you speak a language other than English, call Member Services. We can help you.

If you are deaf or hard of hearing and you use a TTY system, you can still call the Member Services Department. Molina Healthcare uses the Relay NM Service. First dial (800) 659-8331 toll free using the TTY system. A Relay NM Service operator will come on the line. Give the operator Molina Healthcare's toll free telephone number. It is (866) 403-3018. The Relay NM Service operator will help connect you with Member Services.

## If you move

You must call your local Income Support Division (ISD) office to update your address if you move. They will help you update your records. Call Member Services to update your address too.

## New Medical Treatments

Molina Healthcare wants to make sure you get the best care possible. On a regular basis we review procedures and technology relating to healthcare. We take this information into consideration under the benefit plan. Call Member Services if you

want to know how Molina Healthcare makes these decisions.

## Handicapped Access

SCI/UNMCI practitioners/providers must have handicapped access for Members. Call Member Services if you have another special need.

## Filing a Claim

It is the practitioners/providers job to file a claim when you get services. They must do this when Molina Healthcare is the primary coverage. They must send the claim within ninety (90) days from the date you get the service. You must pay your co-payment if one applies. You do not have to pay for the services if you get a referral when needed. You do not have to pay for the services if your practitioner/provider gets a prior authorization when needed. You do not need to file a claim to Molina Healthcare. This is the practitioners/providers job.

# MEMBER RIGHTS AND RESPONSIBILITIES

## Members Rights (Patient Bill of Rights)

1. Members or their legal guardians have a right to ask for information about Molina Healthcare, the Molina Healthcare policies and procedures about products, services, its contracted practitioners and providers, grievance procedures, benefits provided and Members' rights and responsibilities.
2. Members have a right to be treated with courtesy and consideration and with respect and recognition of their dignity and need for privacy.
3. Members or their legal guardians have a right to choose a PCP within the limits of the covered benefits and plan program and the right to refuse care of specific providers.
4. Members or their legal guardians have a right to receive from the Member's practitioner(s)/ provider(s), in terms that the Member or legal guardian(s) understands an explanation of his/

her complete medical condition, recommended treatment, risk of the treatment, expected results and reasonable medically recommended alternatives, irrespective of the health care insurer's position on treatment options. If the Member is not able to understand the information, the explanation shall be provided to his/her next of kin, guardian, agent or surrogate, if available, and noted in the Member's medical record.

5. Members have a right to get health care services in a nondiscriminatory fashion.
6. Members who don't speak English as their first language have the right to access translator services, at no cost, for communication with Molina Healthcare.
7. Members who have a disability have the right to get information in another format in compliance with the Americans with Disabilities Act.
8. Members or their legal guardians have a right to participate with their health care practitioners/providers in decision making in all aspects of their health care, including treatment development and acceptable treatments.
9. Members or their legal guardians shall have the right to informed consent.
10. Members or their legal guardians shall have the right to choose a surrogate decision maker to be involved as appropriate, to help with care decisions.
11. Members or their legal guardians shall have the right to get a second opinion by another practitioner/provider in the SCI/UNMCI program when members need more information about recommended treatment or believe the practitioner/provider is not authorizing requested care.
12. Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
13. Members or their legal guardians have a right to voice complaints, grievances or appeals about Molina Healthcare, the handling of grievances, the care provided, or the HSD Fair Hearing process without fear of retaliation.
14. Members or their legal guardians have a right to file a complaint, grievance or appeal with Molina Healthcare and to get an answer to those complaints, grievances or appeals within a

reasonable time.

15. Members or their legal guardians have a right to pick from available practitioners and providers within the limits of SCI/UNMCI program and its referral and prior approval requirements.
16. Members or their legal guardians have a right to make their decisions known through advance directives about health care decisions consistent with federal and state laws and regulations.
17. Members or their legal guardians have a right to privacy of medical and financial records maintained by Molina Healthcare and its providers.
18. Members or their legal guardians have a right to access the Member's medical records in accordance with the applicable federal and state laws and regulations.
19. Members have the chance to approve or deny the release of identifiable medical or other information by Molina Healthcare, except when such release is required by law.
20. Members or their legal guardians have a right to get information about Molina Healthcare, its health care services, how to access those services, and the program practitioners and providers.
21. Members or their legal guardians have a right to get information about Molina Healthcare's policies and procedures about products, services, practitioner/providers, appeal procedures, getting consent for use of Member medical information, allowing Members access to their medical records and protecting access to Member medical information and other information about SCI/UNMCI and benefits provided.
22. Members or their legal guardians have a right to know upon request of any financial arrangements or provisions between SCI/UNMCI and its practitioners and providers that may restrict referral or treatment options or limit the services offered to the Members.
23. Members or their legal guardians have a right to be free from harassment by SCI/UNMCI or its program practitioners or providers in regard to contractual disputes between SCI/UNMCI and practitioners or providers.
24. Members or their legal guardians have a right to available and accessible services when medically necessary as determined by the PCP or treating practitioner/provider in consultation with SCI/

UNMCI, twenty-four (24) hours per day, seven (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. Members have a right to adequate access to qualified health practitioners/providers near where the Member lives or works, within the service area of SCI/UNMCI.
26. Members have a right to affordable health care, with limits on out-of-pocket expenses including the right to get care from a non-program provider, and explanation of a Member's financial responsibility when services are provided by a non-program provider or non-program practitioner/provider or provided without required pre-approval.
27. Members 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 an enrollee must follow for prior approval and utilization review.
28. Members have a right to request an amendment to their Protected Health Information if the information is believed to be incomplete or wrong.
29. Members or their legal guardians have a right to prompt notification of termination or changes in benefits, services or provider program coverage area.
30. Members have a right to get care from a non-program provider and be advised of their financial responsibility if they get services from a non-program provider, or get services without needed prior approval.
31. Members have the right to continue an ongoing course of treatment for a period of at least thirty (30) days if the Member's practitioner/provider leaves the program, or if a new Member's practitioner/provider is not in the program.
32. Members have the right to make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.
33. Members 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.
34. Members or their legal guardians have the right to select an MCO and exercise switch enrollment rights without threats or harassment.
35. Members or their 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 possible consequences of this decision have been explained in language the Member understands.

36. Members or their legal guardians have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina Healthcare's internal review, the right to a secondary appeal, and the right to request the superintendent's or HSD's assistance as applicable.

## **Member Responsibilities**

1. Members or their legal guardians have a responsibility to provide, to the extent possible, information that SCI/UNMCI and its practitioners and providers need in order to care for them.
2. Members or their legal guardians have a responsibility to understand the Member's health problems and to participate in developing mutually agreed upon treatment goals.
3. Members or their legal guardians have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners/providers.
4. Members or their legal guardians have a responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.
5. Members or their legal guardians have a responsibility to review their Member Handbook and if there are questions, contact the Member Services Department for clarification of benefits, limitations and exclusions. The Member Services telephone number is located on the Member's ID card.
6. Members or their legal guardians have a responsibility to follow Molina Healthcare's policies, procedures and instructions for obtaining services and care.
7. Members or their legal guardians have a responsibility to tell Molina Healthcare immediately of any loss or theft of their ID card.
8. Members or their legal guardians have a responsibility to advise a program provider of coverage with SCI/UNMCI at the time of service. Members may be required to pay for services if they don't inform the program provider of their coverage.

9. Members or their legal guardians have a responsibility to pay all required co-payment and/or coinsurance at the time services are rendered.
10. Members or their legal guardians have a responsibility to be responsible for payment of all services obtained prior to the effective date with SCI/UNMCI and subsequent to termination or cancellation of coverage with SCI/UNMCI.
11. Members or their legal guardians have a responsibility to tell their ISD Caseworker if there is a change in name, address or, telephone number.
12. Members or their legal guardians have a responsibility to tell HSD, SCI/UNMCI and Molina Healthcare if they get medical coverage other than through SCI/UNMCI.

## Your Rights About Your Medical Care (Advance Directives)

You have the right to make choices about your medical care. You can fill out a form that tells your family, practitioners/providers and those who need to know how you want to be cared for during an illness or medical emergency. This is called “Advance Directives.” Call Member Services if you want to know more about this. We can help you.

## PRIMARY CARE PRACTITIONER (PCP) SERVICES

### How the SCI/UNMCI Program Works

Your Primary Care Practitioner (PCP) plans and directs all your medical care. Your PCP will help you get the care you need. Your PCP can help you get other services you may not be able to get in the PCP’s office.

Don’t get care without asking your PCP first. You might have to pay the bill if you do.

### How to Change/Select a PCP

A SCI/UNMCI Provider Directory is included in your member packet. The book lists all the PCPs available. You can use this book to pick a PCP.

Follow the steps listed to pick or change your PCP.

1. You can pick a PCP from the list. Call Member Services for help. You can call us at (505) 348-1578 or toll free at (866) 403-3018. Member Services will check to make sure the PCP you want is taking new members. You can pick a PCP from the following group of practitioners:
  - General/Family practitioner: A practitioner for people of all ages;
  - Internist: A practitioner who treats adults and sometimes teenagers; and
  - OB/GYN: A practitioner who treats women for pregnancy and female health issues.
2. After you pick your PCP, Molina Healthcare will send you an identification (ID) card. Molina Healthcare will send your new ID card within fourteen (14) days of your request. The card will list your PCP’s name, address and telephone number.
3. If you pick your new PCP by the twentieth (20th) of the month, the change will start on the first of the following month.
4. If you pick your new PCP after the twentieth (20th) of the month, the change will start the first day of the second month following the request

After you get your ID card, call your PCP for an appointment. Your PCP will:

- See you for checkups;
- See you when you are sick or injured;
- Tell you when you need to see a specialist or other medical doctor; and
- Be on call if you need care at night or on the weekend.

Take your ID card with you when you go to your PCP. This card shows information about your SCI membership, including your ID number and co-payment amounts.

Your PCP must approve all of the medical care you get except for emergency room visits. If you get care without your PCP’s approval first, you may have to pay the bill. Please call Member Services if you need care and do not have your ID card yet. Member Services can help you make an appointment so you don’t have to pay the bill.

## How to Make Appointments with Your PCP

1. Call your PCP. The number is on your SCI/ UNMCI ID card.
2. Tell the office what kind of problem you are having.
3. The office will give you a date and time to see your PCP.
4. Make sure you go to your appointment. If you can't go, call your PCP at least twenty-four (24) hours before to cancel. You must then call to make a new appointment.
5. Your PCP may send you to an urgent care center or to the emergency room if they feel you need urgent or emergency care.

Remember to call your PCP for advice before you get care anywhere else. Call 911 for medical emergencies. Call Member Services if you have questions. Let us know if you need help with appointments.

## If Your PCP Leaves the Program

We will send you a letter right away telling you about this. We will pick a new PCP for you. You can keep this PCP. You can call Member Services to pick a PCP of your choice. You will get a new ID card.

## Choosing a Specialist as a PCP

If you have a serious long-term illness and are seeing a specialist, your specialist may be able to act as your PCP. Call Member Services to ask about this.

Members may be approved to have a specialist act as their PCP. These decisions are based on continuity of care. They must be approved by the Medical Director. The Member must get a written note from the specialist whom they want as a PCP. The specialist must agree to be a PCP for that Member. The note must include the reason for using the specialist as a PCP. The specialist must send the note to Molina Healthcare's Utilization Management Department at:

Molina Healthcare  
ATTN: Utilization Management  
P.O. Box 3887  
Albuquerque, NM 87190-9859

The specialist can fax the note toll free to (888) 802-5711.

The request will be denied if the specialist doesn't want to be your PCP. The request will be denied if the note doesn't show why the specialist must be your PCP. You and the specialist will be notified of the denial by telephone. This call will happen within twenty-four (24) hours of the denial decision. You and the specialist will also be notified in writing. You will get this notice within two (2) working days after the denial decision. You will be told of your appeal rights. You will be told of your right to select a different PCP.

If you need a specialist as a PCP, the specialist must agree to meet the minimum requirements of Molina Healthcare's PCP care.

## BENEFITS - COVERED AND NON-COVERED

Call Member Services if you have questions about covered or non-covered services. We will answer your questions. A detailed listing of covered services, limitations and exclusions (non-covered services) is included later in this section.

SCI/UNMCI covers all medically necessary services that are offered in the State of New Mexico's State Coverage Insurance (SCI). Medically necessary means that a service is needed to prevent, diagnose or treat a medical condition.

### Some Services that are Covered:

- Primary Care Practitioner (PCP) services.
- Family planning;
- Durable Medical Equipment;
- Emergency ambulance rides;
- Emergency services; and
- Home Health services.

### Some Services that are Not Covered:

- Long-term nursing facility care;
- Unnecessary emergency services;
- Non-medically necessary service;
- Care given by practitioners/providers who are not part of the SCI/UNMCI program, unless they are approved in advance;
- Dental services;
- Routine vision services;

- Acupuncture and chiropractic services; and
- Weight loss programs.

Call Member Services for questions on benefits. Molina Healthcare will let you know if your benefits have changed.

### Services You Can Get Without a Referral from Your PCP

- Family planning;
- OB/GYN;
- Behavioral health; and
- Emergency services.

### Family Planning Services

Members can get family planning services. They do not need to ask their PCP for permission. Females have the right to refer themselves to a Women's Health specialist within the SCI/UNMCI program.

They can get routine and preventive health services.

Examples of services covered under family planning are:

- Tests to help with birth control choice; and
- Follow-up care for problems with birth control.

Call Member Services. We have more information on family planning services.

### Services for Native American Members

Native American Members can self-refer to Indian Health Services (IHS) or 638 Tribal Healthcare Facilities. They can do this for any service. They do not need to ask their PCP for permission. Members that are registered as Native American Members with the Income Support Division do not have co-pays for any SCI services.

### Summary of Most Common Services and Co-payments

These are the most common services. The co-payments are listed by the category you are enrolled in.

Services	Co-payment	Comments
<b>Practitioner/Provider:</b> Clinic Visits	(N00/N05/N07) \$0/ \$5/ \$7	Specialist require a referral
<b>Hospital Inpatient:</b> Medical/Surgical Psychiatric (Behavioral Health Maternity	\$0/ \$25/ \$30 \$0/ \$25/ \$30 \$0/ \$25/ \$30	Non-emergent admissions require a prior approval
<b>Hospital Outpatient:</b> Surgery/Procedures Behavioral Health PET Scans Physical/Occupational or Speech Therapy Cardiac Rehab Therapy Chemo/Radiation Therapy MRI/CT Scans Approved DME/Prosthesis Pharmacy (PDL)	\$0/ \$5/ \$7 \$0/ \$5/ \$7 \$0/ \$5/ \$7 \$0/ \$5/ \$7 \$0/ \$5/ \$7 \$0/ \$5/ \$7 \$0/ \$5/ \$7 \$0/ \$5/ \$7 \$3-all categories	Some services may require prior approval         PDL co-payments are capped at \$12 per month
<b>Emergency:</b> Emergency Room Visit	\$0/ \$15/ \$20	
<ul style="list-style-type: none"> <li>▪ All specialty services require a referral</li> <li>▪ Co-payments are due at the time of service</li> <li>▪ Co-payments are based on income and family size; and</li> <li>▪ Call Member Services for information on benefits, limitations and exclusions not listed here.</li> </ul>		

# Standard SCI/UNMCI Services

Some services may need a prior authorization. Call Member Services to find out which services need a prior authorization before you get the service.

- Primary Care Practitioner (PCP) services: office visits, home visits, routine care, physical exam, office procedures and shots;
- Routine and diagnostic X-rays and clinical laboratory tests, routine electrocardiograms (EKGs) and electroencephalograms (EEGs);
- Inpatient and outpatient surgery (includes assistant surgeon's charges);
- Inpatient professional care services - including pathologists, radiologists and anesthesiologists;
- Inpatient hospital services: These services need prior authorization and your PCP's referral. They are limited to twenty-five (25) days per benefit year. The twenty-five (25) day limitation is combined with home health services and inpatient physical rehabilitation. Benefits include:
  1. Semi-private room and board accommodations, including general duty nursing care;
  2. Private room and board accommodations when medically necessary. A prior authorization is needed;
  3. In-hospital therapeutic and support care, services, supplies, and appliances, including care in specialized intensive and coronary care units;
  4. Use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment;
  5. Laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests done in conjunction with a member's admission to a hospital;
  6. Anesthetics, oxygen, pharmaceuticals, medications, and other biologicals;
  7. Dressings, casts, and special equipment when given by the hospital for use in the hospital;
  8. Inpatient meals and special diets;
  9. Inpatient radiation therapy and/or inhalation therapy;
  10. Rehabilitative services – physical, occupational, and speech therapy;
  11. Administration of whole blood, blood plasma, and components; and
  12. Discharge planning and coordination of services.
- Maternity Care;
- Outpatient hospital services that can reasonably be provided on an ambulatory basis (Needs prior authorization and your PCP's referral);
- Surgeries, including use of operating, delivery, recovery and treatment rooms, equipment and supplies including anesthesia, dressings and medications;
- MRI, CT Scans, and Positron Emission Tomography (PET) tests;
- Radiation therapy and chemotherapy;
- Holter monitors and cardiac event monitors;
- Rehabilitative services – including heart and short-term physical, occupational, and speech therapies;
- Emergency and post stabilization care - including twenty-four (24) hour emergency medical care and emergency room service;
- Same day care or urgent care and urgently needed health services;
- Women's health services;
- Mammography and cytological screening;
- Services related to the diagnosis, treatment and appropriate management of osteoporosis;
- Prenatal and post partum care;
- Preventive health services including physical exams and periodic tests;
- Family planning services (including birth control pills, supplies and devices, surgical procedures to cause sterility or prevent pregnancy);
- Dialysis services;
- Inpatient physical rehabilitation services (limited to twenty-five [25] days per benefit year combined with the inpatient hospital and home health services);
- Home health services (limited to twenty-five [25] days per benefit year combined with the inpatient hospital and rehab services);
- Ambulance service (emergencies only):
- Limited oral surgery;
- Limited reconstructive surgery;
- Prescription Drugs; and
- Diabetes treatment services; equipment, supplies and appliances to treat diabetes including:
  1. Blood glucose monitors, including those for the legally blind;
  2. Test strips for blood glucose monitors;
  3. Visual reading urine and ketone strips;

4. Lancets and lancet devices;
  5. Insulin (limit two [2] vials per co-payment);
  6. Injection aids, including those adaptable to meet the needs of the legally blind;
  7. Syringes;
  8. Prescriptive oral agents for controlling blood sugar levels; and
  9. Medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and Glucagon emergency kits.
- Behavioral Health Services (includes inpatient hospitalization, outpatient psychiatric care and outpatient psychotherapeutic services.) (See Limitations);
  - Alcohol and Drug Abuse Services (Includes outpatient for Adults);
  - Durable Medical Equipment (DME) (wheelchairs, walkers, oxygen, etc.) (See Limitations);
  - Prosthetics and Orthotics (See Limitations);
  - Organ Transplants (heart, lung, heart-lung, liver, kidney, corneal and certain kinds of bone marrow) (See Limitations); and
  - Health Education.

## How to Get a Second Opinion

A second opinion is when you ask to see another practitioner/provider about your medical condition. You can get a second opinion from another SCI/UNMCI practitioner/provider. If a qualified practitioner/provider isn't available in the network, you have the right to get a second opinion. You can get a second opinion from a qualified practitioner outside of the network. Call Member Services if you think you need a second opinion.

## Enhanced SCI/UNMCI Services

Hospice care is given as an extra SCI/UNMCI service at UNM Hospitals. Hospice is a service to care for a patient with a terminal illness. The patient usually has a life expectancy of six (6) months or less. Licensed hospice programs in the state of New Mexico provide support and comfort to the patient

and the family during the final months of life. Hospice services offer palliative care, which gives relief from pain and other symptoms, rather than curative treatment. The goal of hospice is to make sure that a patient's remaining time is as pain-free and peaceful as possible.

Hospice care improves the quality of life for the patient. It provides a personalized plan of care that focuses on the patient's comfort and dignity. Hospice staff respects the wishes of the patient. They encourage communication among family members and the medical team.

## Behavioral Health Services

Behavioral health services include psychosocial rehabilitation and mental health outpatient services.

## Behavioral Health and Your Primary Care Practitioners (PCPs) role

Some behavioral health problems can be treated in a PCP setting. Others need the care of a behavioral health practitioner/provider. When it is decided that a specialized level of care is needed, your PCP can refer you for the level of care you need.

SCI/UNMCI asks that you sign a Release of Information. This helps your PCP and behavioral health practitioner/provider work together. They will make sure you get the care you need.

## Getting Behavioral Health Services

Behavioral health services do not need a referral from your PCP. You are encouraged to let your PCP know that you are getting behavioral health care.

You can go directly to a SCI/UNMCI behavioral health practitioner/provider. They will review your needs. You do not need to call the Member Services Department first. Call Member Services if you need help finding a behavioral health practitioner/provider that meets your needs. We will help you.

If you have a behavioral health emergency, go to the emergency room.

## **Finding the Right Behavioral Health Practitioner/Provider**

The SCI/UNMCI program has a variety of licensed behavioral health practitioners/providers. Member Services can work with you. We will help you find the right behavioral health practitioner/provider to meet your needs.

## **Behavioral Health Practitioners/Providers Outside the SCI/UNMCI Program**

If you choose to go to a practitioner/provider who is not in the SCI/UNMCI program, you will have to pay the bill. In the case of an emergency, you can get emergency services to treat your condition.

## **Prior Approvals (authorizations) for Behavioral Health Services**

Some behavioral health services need to be pre-approved. Call Member Services. We will tell you which services need to be pre-approved.

## **Covered Behavioral Health Services**

Behavioral health services are covered for a range of behavioral health problems. Call Member Services. We will give you benefit information.

## **Services Requiring Prior Authorization**

Prior authorization is a review of the service asked for. The service will need to be looked at by the medical director. The medical director will decide if the test, equipment or procedure meets the criteria for "medically necessary." Within one (1) to five (5) days, both the patient and the PCP will be told if an authorization or a denial is given. If a denial is given, the patient and/or practitioner/provider can appeal the decision.

The following is a list of tests and procedures that will need prior authorization:

### **Heart station procedures:**

- Dobutamine ECHO (DOB);

### **Radiology/imaging procedures:**

- MRIs;
- PET Scanning; and
- Interventional Radiology.

Elective inpatient admission

Neuropsych testing

Physical Therapy and Occupational Therapy (after initial consultation and treatment visit)

Inpatient rehabilitation services

Home health services

Durable medical equipment (DME)

Oral and reconstructive surgery

Inpatient behavioral health and detoxification

## **SCI/UNMCI Benefit Limits**

In each benefit year the SCI benefit package is limited to \$100,000 in benefits, twenty-five (25) days physical health inpatient services, combined with home health services and inpatient physical rehabilitation, and twenty-five (25) days behavioral health inpatient services. The cost for all your services, as well as the number of inpatient days used, will be tracked. You will be told when you have used \$50,000, \$85,000 and \$100,000 of services or fifteen (15), twenty (20) and twenty-five (25) inpatient days. UNM will coordinate with HSD to make sure members continue to get care through some other program if either the claims and/or hospital maximums are reached.

## **Service Limitations**

Covered services are subject to the following conditions and limitations:

1. Medically Necessary services are clinical and rehabilitative physical, mental or behavioral health services that:
  - A. Are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
  - B. Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;
  - C. Are provided within professionally

- accepted standards of practice and national guidelines; and
- D. Are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider, or the payer.
2. Behavioral Health and Substance Abuse Services:
    - Outpatient behavioral health services don't need a prior authorization for the first six (6) sessions per benefit year. Sessions over six (6) will need a prior authorization. The behavioral health Outpatient Program is limited to forty-two (42) days per benefit year.
    - Inpatient behavioral health services and partial hospitalization are limited to twenty-five (25) days per benefit year.
    - Inpatient substance abuse detoxification is limited to seventy-two (72) hours (three [3] days) per occurrence as part of the total twenty-five (25) day benefit for inpatient behavioral health services.
    - Outpatient substance abuse detoxification services are limited to ten (10) days per benefit year. Substance abuse outpatient services including outpatient services are limited to forty-two (42) days per benefit year.
  3. Cardiovascular Rehabilitation  
Coverage for cardiovascular rehabilitation is limited to a maximum of thirty-six (36) sessions per cardiac event.
  4. Choice of Provider  
For the purpose of coverage under this policy, Molina Healthcare has the right to decide which practitioner/provider can be used to provide the covered services.
  5. Contact Lenses or Eyeglasses Following Cataract Surgery  
One (1) complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is limited to either one (1) set of contact lenses or eyeglasses per member per surgery. The maximum amount of coverage for materials (contact lenses or eyeglasses) is limited to \$300 per surgery. Coverage for contact lenses or eyeglasses is limited to ninety (90) days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the ninety (90) day period are not covered.
  6. Dental Services  
In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury must be properly documented during the initial treatment. Services must be completed within twelve (12) months of the date of injury. UNM Hospitals will require dental x-rays.
  7. Detoxification  
Inpatient detoxification is limited to seventy-two (72) hours of inpatient services per occurrence as part of the twenty-five (25) day benefit for inpatient behavioral health services. Outpatient detoxification is limited to ten (10) days per benefit year.
  8. Home Health Services  
Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation, may not exceed twenty-five (25) days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.
  9. Inpatient Hospitalization, Home Health Services, Inpatient Rehabilitation  
This policy is limited to maximum of twenty-five (25) combined days per member per benefit year for inpatient hospitalization, home health services, and inpatient rehabilitation combined.
  10. Major Disasters  
In the event of any major disaster, epidemic, or other circumstance beyond its control, Molina Healthcare will render or attempt to arrange covered services with participating practitioners/

providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include:

- Complete or partial disruption of facilities;
- War;
- Riot;
- Civil uprising;
- Disability of UNM Hospitals personnel;
- Disability of participating providers; or
- Act of terrorism.

#### 11. Maternity Transportation

Coverage for transportation is provided when medically necessary to protect the life of the infant or mother, including air transport if indicated, for medically high-risk pregnant women with an impending delivery of a potentially viable infant, to the nearest available tertiary care center.

#### 12. Mastectomy and Lymph Node Dissection

Length of inpatient stay: not less than forty-eight (48) hours inpatient stay following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection when deemed medically appropriate by physician and patient.

#### 13. Orthotic Appliances and Prosthetic Devices

Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

#### 14. Physical, Speech and Occupational Therapy

Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two (2) consecutive months per member per condition.

#### 15. Post Mastectomy Supplies

Bras required in conjunction with reconstructive surgery are limited to two (2) per member per benefit year.

#### 16. Prescription Drugs

Prescription drugs are limited to generic drugs and name brand prescription drugs as listed on the UNM Hospitals SCI Preferred Drug List (PDL).

- A. For each co-payment amount, quantities are limited to a thirty (30) day supply or one hundred (100) tablets, whichever is less, per prescription or refill. All other units will be dispensed in a thirty (30) day supply, with

one (1) co-payment required for each of the following quantities:

- i. Topical products. The lesser of eighty (80) grams of cream or ointment or sixty (60) ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.
- ii. Oral liquids. Four hundred eighty (480) ml. maximum per co-payment.
- iii. Inhalers and vials. One (1) co-payment per unit (diabetic insulin exception – two [2] vials of the same type of insulin per co-payment).
- iv. Manufacturer's trade package. One (1) co-payment per trade package (i.e. Imitrex, estrogen patches).
- v. Mail order drugs are limited to drugs available through the UNM Hospital's pharmacy.

#### 17. Transplants – Organ, Bone Marrow, and/or Tissue

A. Organ, bone marrow, and/or tissue transplants are limited to:

- i. Heart;
- ii. Heart/lung;
- iii. Lung;
- iv. Liver;
- v. Cornea;
- vi. Kidney;
- vii. Skin
- viii. Bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, Severe Combined Immunodeficiency Disease, Wiskott-Aldrich Syndrome, advanced Hodgkins or non-Hodgkins lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas).
- ix. Pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

B. No other transplant procedures are covered. Molina Healthcare has the right to require that transplants be performed at contracted Centers of Excellence if one is available.

C. A member is eligible for coverage for up to two (2) transplants per lifetime. Multiple organ, bone marrow, and/or tissue transplants performed at the same time

are considered to be one (1) procedure. All transplant services are limited by the \$100,000 annual benefit limitation and twenty-five (25) bed day benefit limitation per member per benefit year.

## Services Not Covered

SCI does not cover any service or supply not specifically listed as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well.

The list of exclusions below is not meant to be exhaustive, but is meant to be of assistance to members. If a service is not listed as a covered service, then it is not covered regardless of medical necessity. Other services excluded are:

1. Services not coordinated through a Member's PCP or lacking a prior authorization Health services and supplies are not covered if they are not provided by or under the direction of:
  - A. The member's PCP or a practitioner/provider to whom the Member has been referred by his PCP;
  - B. A non-participating practitioner/provider to whom the Member has been referred by his PCP, and a prior authorization is in place for those services; or
  - C. Any services or supplies that require a prior authorization if a prior authorization is not obtained.
2. Services not medically necessary, not standard medical practice, or experimental  
The following services are not covered:
  - A. Any treatment, procedure, facility, equipment, drug, drug use, device, or supply that is not medically necessary. Molina Healthcare pays only for medically necessary services furnished by approved providers to eligible recipients. Molina Healthcare does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, or other products or devices, except routine patient costs associated with certain Phase I, II, III,

and IV cancer clinical trials.

- B. Drugs and devices that are not Federal Drug Administration (FDA) approved, not FDA approved for the proposed use, or which have been voluntarily removed from the market. Please consult the UNM Hospitals (UNMH) Pharmacy if you have any questions about FDA approval. You may call the UNMH pharmacy at (505) 272-2309 Monday through Friday, 7:00 AM to 5:00 PM.
  - C. Medical, surgical, and/or behavioral health procedures, pharmacological regimes, and/or associated health services, if they are experimental, under investigation, or generally not standard medical practice.
3. Acupuncture and Chiropractic Services  
Acupuncture and chiropractic services are not covered.
  4. Assistant Surgeon Services  
Payment for assistant surgeon services when the SCI/UNMCI program does not approve an assistant surgeon is not covered.
  5. Behavioral Health  
The following behavioral health services are not covered:
    - A. Behavioral health services that are rendered in connection with disorders not classified in the International Classification of Diseases, 9th Revision and Clinical Modification (ICD-9-CM).
    - B. Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, day treatment, and neurobehavioral programs.
  6. Cosmetic Services  
Cosmetic services are not covered, including but not limited to:
    - Surgery, services, or procedures to change family characteristics or conditions due to aging;
    - Dermabrasion;
    - Scar reconstruction or revision;
    - Acne surgery (including excision of scarring and cryotherapy); tattoo removal;
    - Orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body; surgical

- excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy;
  - Sclerotherapy; liposuction; rhinoplasty; otoplasty;
  - Services related to a cosmetic service, or required as a result of a non-covered cosmetic service; surgery required as a result of a non-covered procedure (such as a noncovered organ or tissue transplant or a sex change operation) or additional surgery or treatment required to care for or correct a complication due to a previous cosmetic service;
  - Breast augmentation, reduction mammoplasty, or nipple reconstruction except as related to reconstructive surgery.
7. Court Ordered Care  
Court mandated evaluations and treatment that would not be in compliance with the terms and conditions of the SCI/UNMCI contract are not covered.
8. Coverage Out of the Service Area  
Coverage while away from service area, except for emergency health services and urgently needed health services, is not included, unless otherwise covered.
9. Custodial Care  
Custodial or home (domestic) care, including services and supplies that can be performed by non-licensed medical personnel to help a member meet the normal activities of daily living, are not covered. Examples of custodial care that are not covered services are:
- A. Bathing;
  - B. Feeding;
  - C. Preparing meals; and
  - D. Performing housekeeping tasks.
10. Dental Services  
The following dental services are not covered:
- A. All general dental services and dental x-rays, including but not limited to:
    - i. Anesthesia and facility services for dental restoration;
    - ii. Removal of impacted teeth;
    - iii. Removal of tori or exostoses;
    - iv. Procedures involving orthodontic care, the teeth, dental implants and periodontal disease;
  - v. Artificial devices, surgery on the supporting structures of the teeth, and bone grafts to prepare the mouth for denture wear;
  - vi. Personalized restorations, cosmetic replacement of serviceable restorations, or materials that are more expensive than necessary to restore damaged teeth; or
  - vii. Surgical realignment of the jaw structures for functional malocclusion.
- B. Orthodontics, endodontics, and dental prosthetics.
- C. Orthotic and orthodontic appliances and/or treatment, crowns, bridges, and/or dentures used for the treatment of craniomandibular and temporomandibular joint disorders.
11. Donor Services  
Medical and hospital services for a donor when the recipient of an organ, bone marrow, and/or tissue transplant is not a member, or when the transplant procedure is not a covered service and/or is not included in the benefit package.
12. Durable Medical Equipment, Medical Supplies; Prosthetic Devices; Orthotic Appliances  
The following are not included in the benefit package:
- A. Durable Medical Equipment, Medical Supplies
    - i. Equipment that is non-medical in nature such as voice synthesizers or other communication devices, waterbeds, Jacuzzi units, hot tubs, whirlpools, swimming pools, exercise equipment, heating pads, or hot water bottles;
    - ii. Air conditioners, humidifiers, purifiers, or self-help devices, biofeedback equipment, and tens units;
    - iii. Deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds, when standard equipment is available and adequate to meet functional requirements;
    - iv. Repairs to equipment that is not owned by the member, or repairs to equipment that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new

- unit;
  - v. Comfort or safety items such as bed boards, hospital beds, or mattresses, flotation mattresses, bathtub lifts, grab bars, over bed tables, adjustable beds, telephone arms, diapers, underpads;
  - vi. Sphygmomanometers, stethoscopes, and blood pressure monitors; and
  - vii. Medical supplies and equipment that can be purchased over the counter such as shower chairs, elevated toilet seats, alcohol pads, and dressing supplies.
- B. Prosthetic Devices
- i. Prosthetic devices unless they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement;
  - ii. External prosthetic devices that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;
  - iii. Cosmetic coverings for external prosthetic devices;
  - iv. Repairs of prosthetic devices that are not owned by the Member; and
  - v. Cochlear implants.
- C. Orthotic Appliances
- i. Accommodative orthotic appliances; orthopedic shoes and shoe orthotic appliances (except when the shoes are attached and an integral part of the brace), arch supports, shoe inserts, special-ordered shoes, custom shoes, built up shoes of any type, and other supportive devices for the feet, except for the management of diabetes as required by law;
  - ii. Orthopedic appliances that can be purchased over the counter;
  - iii. Cranial banding services; and
  - iv. Penile prostheses.
13. Eyeglasses and Vision Services
- The following eyeglasses and vision services are not included in the benefit package:
- A. Eye refractions, eyeglasses, and contact lenses, and/or the fitting thereof, and routine vision services, except for contact lenses or eyeglasses following cataract surgery; and
  - B. Surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses, except for intraocular lenses in connection with cataract removal.
14. Genetic Testing
- Genetic testing, screening (other than by triple serum test only) and counseling, with the exception of genetic testing for the diagnosis or treatment of a current illness, are not included in the benefit package.
15. Health Clubs
- Fees for health clubs, spas, and exercise programs are not included in the benefit package.
16. Hearing Aids
- The purchase of hearing aids, and/or the fitting thereof, associated hearing aid testing, and other artificial aids.
17. Illegal Acts or Crimes
- The following is not covered:
- A. Injury or illness sustained during the voluntary participation in a riot or the commission of an illegal act or crime, or while under the influence of alcohol or other drug or controlled substance, which is not prescribed by a provider.
- For purposes of this section, a person will be presumed to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by UNM Hospitals. The limitations of this section will not apply unless there is a direct causal relationship between the activity described above and the illness or injuries sustained.
18. Infertility Treatment
- Infertility treatment services are not covered.
19. Learning Disorders
- Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance, are not included in the benefit package.

20. Marital Therapy or Counseling  
Marital therapy or counseling is not covered.
21. Missed Appointments  
Costs incurred in conjunction with missed appointments are not included in the benefit package.
22. Modifications, Improvements, Equipment  
Home, workplace, and automobile modifications, improvements, or equipment are not included in the benefit package.
23. No Legal Obligation to Pay  
The following are not included in the benefit package:
  - A. Services a Member is eligible to receive and has received under any governmental program for which in the absence of any health services or insurance plan, no charge would be made to the Member; and
  - B. Services or supplies for which the Member has no legal obligation to pay or for which no charge would be made if the Member were not eligible for SCI.
24. Paternity Tests  
Diagnostic tests to establish paternity of a child or unborn child are not included in the benefit package.
25. Physical Examinations  
The following physical examinations are not included in the benefit package:
  - A. Routine physical examinations, vaccinations, and/or immunizations if given for:
    - i. The purpose of obtaining employment, insurance, passports for travel; or
    - ii. For the purpose of medical research.
  - B. Sports and school physicals, unless done in conjunction with periodic health assessments.
26. Physical, Speech, Occupational Therapy – Long Term  
All long-term physical, speech, and occupational therapy services are not included in the benefit package.
27. Physical, Speech, Occupational Therapies  
Physical, speech, occupational therapies for the following conditions are not covered:
  - A. Psychosocial speech delay including delayed language development and developmental apraxia;
  - B. Mental retardation, down syndrome, autism, autism spectrum disorders, or dyslexia;
- C. Syndromes associates with diagnosed disorders attributed to perceptual and conceptual dysfunctions;
- D. Learning disabilities, developmental articulation and language disorders, and stuttering; and
- E. Sensory disorders (oral and tactile aversions).
28. Podiatry and Foot Care  
The benefit package does not include podiatry or foot care, including but not limited to: bunion treatment, callous treatment, corn paring or excision and toenail trimming, except in the treatment of insulin-dependent diabetics. Foot massage of any type, the treatment of fallen arches, flat feet, pronated feet, and shock wave treatment are not included in the benefit package.
29. Prenatal, Delivery, Post-partum Services
  - A. All services related to the prenatal period, delivery, and post-partum must be received in UNM service area.
  - B. Tests to determine the gender of an unborn child are excluded from coverage.
30. Prescription Drugs  
The following are excluded from coverage:
  - A. Brand name non-PDL (Preferred Drug List) prescription drugs without prior approval;
  - B. Drugs which do not require a physician's prescription; except insulin;
  - C. Contraceptive jellies, creams, foams, devices or implants (except legend contraceptive devices);
  - D. Therapeutic devices or appliances;
  - E. Drugs whose sole purpose is to promote or stimulate hair growth (such as, Rogaine®, and Propecia®) or for cosmetic purposes only (such as Renova®);
  - F. Biologicals, blood, or blood plasma products;
  - G. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
  - H. Medication for which the cost is recoverable under any Workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical

service for which no charge is made to the Member;

- I. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution, which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
  - J. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one (1) year from the physician's original order; and
  - K. Charges for the administration or injection of any drug.
31. Pulmonary Rehabilitation  
Pulmonary rehabilitation is not included in the benefit package.
32. Recovery  
Services and supplies that are otherwise covered to the extent that a member realizes a recovery from any source are not included in the benefit package.
33. Repair or Replacement for Lost, Stolen, or Damaged Items  
Repair or replacement for lost, stolen, or damaged items listed below are not included in the benefit package:
- A. Durable medical equipment;
  - B. Medical supplies;
  - C. Orthotic appliances;
  - D. Prosthetic devices; and
  - E. Prescription drugs.
34. Services, Supplies for Excluded Services  
Services, supplies, or drugs used for non-covered or excluded procedures or treatment, or used for any related complication(s), are not included in the benefit package.
35. Services, Supplies not Primarily Medical  
Services, supplies, and self-help items that are not primarily medical in nature, for personal comfort or safety, convenience, or beautification during an inpatient stay or in the home setting are not covered. Examples include but are not limited to: facial tissues, diapers, shampoo, under pads, grab bars, and exercise equipment.
36. Sex Transformation  
Sex transformation surgery and all expenses in connection with such surgery are not included in the benefit package.
37. Sexual Dysfunction  
Treatment for sexual dysfunction, including medication, counseling, and clinics, is not included in the benefit package.
38. Sterilization Reversal  
Any service related to reversal of sterilization is not included in the benefit package.
39. Substance Abuse and/or Tobacco Use  
Treatment to prevent the following is not included in the benefit package:
- A. Inpatient substance abuse treatment other than detoxification; and
  - B. Nicotine medications, gums, services, or supplies to aid in the treatment of addiction to tobacco or tobacco products. Nicotine withdrawal treatments including hypnosis, biofeedback, guided imagery, and other forms of relaxation training or subliminal suggestions used to modify tobacco use.
40. Therapies  
Therapies including, but not limited to: exercise, massage, hypnotherapy, sensory, hippo, aquatic, oral aversion, visual training, recreational, sleep, stress management, scream, and myotherapy are not included in the benefit package.
41. Travel/Lodging Expenses  
Travel and lodging expenses are not included in the benefit package.
42. Vocational Rehabilitation Services  
Vocational rehabilitation services are not included in the benefit package.
43. War, Terrorism, Armed Forces  
Any illness and/or injury resulting from war, an act of terrorism, or an act of war or service in the armed forces of any country are not included in the benefit package; to the extent covered services of such illness and/or injury are provided through any governmental plan or program.
44. Weight Loss  
Surgery, medications, and related services for the purpose of weight reduction or control are not included in the benefit package.

#### 45. Worker's Compensation

Industrial, work-related, or occupational illnesses, injuries, or conditions subject to federal, state, or other worker's compensation or liability law or other legislation of similar purpose are not included in the benefit package, unless the group is an employer not subject to the New Mexico Worker's Compensation Act or similar legislation.

#### 46. Miscellaneous

The following miscellaneous items are not included in the benefit package:

- A. Charges associated with copying or transferring health information;
- B. Consultations by environmental engineers;
- C. Devices, medications, and treatments to remove hair due to excessive hair growth;
- D. Holistic medicine and/or biofeedback;
- E. Treatments, medications, prosthetic devices, and orthotic appliances to treat hair loss;
- F. Bone density screening with ultrasound devices; and
- G. Telephone visits by a provider or environmental intervention or consultation by telephone for which a charge is made to the member, and getting acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.

### **What to Do if You Have an Emergency Need for Durable Medical Equipment (DME)?**

Some DME, like oxygen or a ventilator, is very important. It can be serious if the machine breaks or the oxygen tank runs out. Call your DME provider for help if you have an emergency with your DME. Keep their phone number where you can find it. You can put the phone number on the equipment. You can put it on your refrigerator. This will help you find the number in an emergency.

Call 911 if you are in immediate danger. You can get emergency DME from your DME provider. You do not have to contact Molina Healthcare. Your DME provider will get approval later.

Reorder supplies you use on a regular basis. Order them from your DME provider. Supplies can be

ordered during regular business hours. Molina Healthcare can give a prior approval for certain DME supply refills. These referrals may last as long as a year. Call your DME provider if your DME is not working like it should. Call them during regular business hours for help.

Call Member Services if you can't get the help you need from your DME provider. We have someone on call twenty-four (24) hours a day for urgent or emergency needs. We will help you get the DME supplies and equipment that can't wait until the next business day.

## **EMERGENCY/URGENT SERVICES**

### **Emergency Care**

An emergency is when you need care right away. You need emergency care because of an injury or sudden illness. Here are some examples of emergencies:

- Broken bones;
- Bleeding that doesn't stop;
- Heart attacks;
- Major burns; or
- Drug overdoses.

SCI/UNMCI will only cover true emergency services outside of University Hospital. Emergency services are defined by the layperson standard: when a Member, who in good faith and with average knowledge of health and medicine, gets care for what seems to be an acute situation and needs immediate medical care.

If you are sick but it's not an emergency, call the Statewide Nurse Advice Line. You can call them toll free at (877) 725-2552.

### **What to Do In an Emergency?**

Go to the nearest emergency room if you have an emergency. Tell them you are covered under SCI/UNMCI. Show them your SCI/UNMCI ID card.

If you are not sure if you need to go to the emergency room for medical care, call the FREE Statewide Nurse Advice Line. Call them toll free at (877) 725-2552. The nurse will ask you questions. The nurse will tell you who to call or where to go for care. If you need medical care, but it is not a serious or life-threatening emergency call your PCP.

Call 911 if you have a serious health problem or accident. You can go to the nearest emergency room. Tell the emergency room person who your PCP is. Call your PCP as soon as possible. Let him/her know about your emergency.

Follow-up care is not an emergency. You should call your PCP's office to set up follow-up care if you need it. You can also call Member Services to set up follow-up care.

Don't go to the emergency room for care you can get in your PCP's office. Call the Nurse Advice Line if you have a question about using the emergency room. They will help direct you to the right care.

Here are some examples of when you should not use the emergency room:

- Sore throats;
- Cold or flu;
- Back pain; or
- Tension headaches.

Do not wait until after office hours to get care.

You can reach the Statewide Nurse Advice Line twenty-four (24) hours a day, seven (7) days a week. When you are sick, injured or not feeling well, experienced nurses will talk with you. They will help direct you to the right care.

If you are not able to reach your PCP or talk with the practitioner/provider on-call, you can call the Statewide Nurse Advice Line. You can call them toll free at (877) 725-2552.

## **Getting Emergency Care While Traveling**

If you are very sick or seriously injured and need treatment right away, go to the nearest emergency room.

After emergency care, call your PCP within forty-eight (48) hours. Tell him/her what kind of care you got.

Member Services can help you with medical care information. The Statewide Nurse Advice Line can help you with medical care information. We can do this when you are traveling.

## **If an Emergency Room Visit is Necessary**

It is important to take information about yourself to the emergency room. You should have information about:

- Medications (including over the counter medication);
- Allergies;
- Diagnoses;
- PCP or Specialist name and telephone number;
- Medical equipment provider (if applicable);
- Pharmacy; and
- Home care provider (if applicable).

## **Urgent Care**

Urgent care is when you must get treatment within eighteen (18) to twenty-four (24) hours. Check with your PCP first before you get urgent care. The PCP should see you if the urgent need is during regular office hours. Call Member Services if there are problems getting in to see your PCP. We will try to help you get seen.

## **How to Get Services After Hours**

Call your PCP if you think you need urgent medical care. If you can't reach your PCP or the practitioner/provider on-call, call the Statewide Nurse Advice Line. You can call them toll free at (877) 725-2552.

## **Contact with Your PCP**

If you get emergent or urgent care you should tell your PCP within forty-eight (48) hours. Your PCP may need to see you for follow-up care.

# NURSE ADVICE LINE

## Statewide Nurse Advice Line

Nurses can help you by phone. They are available twenty-four (24) hours a day, seven (7) days a week. They are available on holidays. They can help you with health questions. They can tell you what medical care you may need. If you can't reach your PCP or speak with the practitioner/provider on call, you can call the Statewide Nurse Advice Line. They can be reached toll free at (877) 725-2552.

# PHARMACY SERVICES

## Filling Prescriptions

There may be times when your practitioner or provider prescribes medicine. The prescriptions for your medications can be filled at the University of New Mexico Hospital (UNMH) Pharmacy.

The UNMH Pharmacy is located at 1209 University Blvd., N.E. The pharmacy hours are:

- Monday – Friday 7:00 a.m. to 5:00 p.m.
- Saturday 9:00 a.m. to 5:00 p.m.

The telephone number is (505) 272-2308. Call them if you have questions.

You can get information about the pharmacy on the UNMH web site. Visit <http://hospitals.unm.edu/Pharmacy/PharmacyIndex.shtml>. Formulary updates can be viewed on-line. Call Member Services if you have questions.

## Exceptions to Denied Medications

SCI/UNMCI uses a special list of medications. It is called a Preferred Drug List (PDL). Your doctor can ask UNMH to cover medication that is not on this list. This is called an "exception".

Your practitioner/provider can ask for a prior authorization. They ask Molina Healthcare for the prior authorization. If your practitioner/provider request for an exception is not approved, you have a right to appeal that decision. You have a right to

get another review. You will get a denial letter from Molina Healthcare. Your practitioner/provider will get a denial letter from Molina Healthcare. The letter will tell you how to ask for an appeal.

## Medication Refills

The pharmacy can give you a refill on your medication. You can get a refill if your practitioner/provider has ordered one. The pharmacy can't refill your medication more than five (5) days before of the refill date. They can't refill it before three-fourths (3/4) of your medication has been used.

## Questions About Medication

The pharmacist can answer questions you have about your medication. Make sure you know how to take your medication. Tell the pharmacist if you have allergies to medication or foods. Tell your PCP and pharmacist about other medications, vitamins or herbal remedies you are taking.

If you are having problems with your medication, talk to your practitioner/provider right away. Your practitioner/provider need to know if you are having problems.

## Pharmacy Co-Payment Tracking

The UNMH Pharmacy will apply a \$3.00 co-payment for each prescription you fill. There is a maximum co-payment of \$12.00 per month. The co-payments are for medications that have been approved or are on the PDL. After the first four (4) \$3.00 co-payments are made, within the same month, you won't owe any more pharmacy co-payments for the rest of that month.

## Prescriptions Issued by Non-UNMH Practitioners/Providers

It is UNMH's policy to not fill prescriptions from non-UNMH practitioners/providers. If you have a prescription that needs to be filled, you must take it to your UNMH PCP to be rewritten. You can do this in person. An appointment is not needed.

## Prescription Mail Services

At the end of this handbook you will find a form for prescription mail services. Complete the form as directed. If you have questions about the form call Member Services. We can help you.

## BIRTHING OPTIONS PROGRAM

If you are pregnant and eligible for SCI/UNMCI, you have a choice of who will provide care for you. You can also choose where your baby will be born. Women in New Mexico have choices about where to give birth:

- A birth center;
- A hospital; or
- Your own home.

Many health care practitioners/providers offer pregnancy-related services. Many times they work together to provide care for you and your baby:

- Certified Nurse-Midwives\*;
- Family Practice Physicians;
- Licensed Midwives\*;
- Nurse Practitioners;
- Obstetricians; and
- Physician Assistants.

Services for pregnant women may include:

- Prenatal care;
- Case Management;
- Childbirth education;
- Doula services (where available);
- Birthing services for Labor and Delivery;
- Postpartum care;
- Breastfeeding counseling;
- Reproductive Health; and
- Family planning.

If you would like to select out-of-hospital services provided by a midwife\*, please provide the following information by mail:

- Your name;
- Your address;
- Your telephone number;
- Name of midwife; and

- Telephone number for the midwife you have chosen.

Mail this information to the following address:

Pregnancy-Related Services

Benefits Bureau

HSD-MAD

P.O. Box 2348

Santa Fe, New Mexico 87504-2348

Or call the Medical Assistance Division toll free at (888) 997-2583. For more information about the services that are provided by midwives\*, please contact:

### **New Mexico Midwives Association\***

Toll free at (888) 332-4784

or in Albuquerque at (505) 924-2169.

### **American College of Nurse-Midwives**

New Mexico Chapter

<http://nmmidwives.org/practices.php>

### **Maternal Health Program Department of Health**

In Albuquerque at (505) 476-8908.

\* These services are only covered if they are provided by healthcare providers who have an approved Provider Agreement with the Human Services Department/Medical Assistance Division.

## INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN)

### **How Do I Know if I am an Individual with Special Health Care Needs (ISHCN)?**

The State of New Mexico says Individuals with Special Health Care Needs (ISHCN):

- Have or are at an increased risk for an ongoing physical, developmental, or behavioral/emotional condition;
- Need health and related services that are different from the services needed by most individuals; and
- Need help getting through the health care system.

Molina Healthcare uses this list. It helps us decide who needs Care Coordination/Complex Medical Case Management (CC/CMCM) services. You can ask for CC/CMCM services. Call Member Services.

## **ISHCN Information Packet**

You can get a packet from Molina Healthcare. It has information on:

- How to get CC/CMCM;
- Places in the community to get help;
- Logs to keep track of practitioner/provider visits;
- Logs to keep track of medicines you are taking; and
- How to get Durable Medical Equipment (DME) in an emergency.

Call Member Services to ask for a packet. Call Member Services to ask for an ISHCN Coordinator.

## **ISHCN Educational Programs**

Molina Healthcare has educational programs for the caregivers of ISHCN. Call Member Services. Ask for an ISHCN Coordinator. They can give you information about the programs.

# **UTILIZATION MANAGEMENT (UM) SERVICES**

## **What is Utilization Management (UM)?**

We want to make sure you get the right kind of medical care. Our UM Department works hard to make sure you do.

There are times when the care you need requires prior approval from Molina Healthcare. This is when our UM Department looks at your medical needs. This is to make sure the kind of medical care being asked for is the best care for you. Only a Medical Director can decide if any of your medical care won't be approved. Our practitioners/providers and nurses do not get any money or compensation for denying services or payment for care.

After you get medical care, Molina Healthcare looks at your records. This is to make sure you got the

medical care you needed. This UM review helps us make sure that you got the right care.

If you have questions, call Member Services between 8:00 a.m. and 5:00 p.m., Monday – Friday (except holidays).

## **What are Prior Approvals and Specialist Referrals?**

Some services and prescriptions need prior approvals. Your PCP or specialist will decide if you need one of these services. Your PCP or specialist will ask Molina Healthcare for approval. You need a referral from your PCP before you see a specialist. You may have to pay the bill if you get services without prior approval or a referral from your PCP.

## **How to Get PCP, Specialist or Hospital Services**

You should make an appointment with your PCP when you have picked one. It is important to meet your PCP. Make an appointment even if you are not sick. This will help your PCP get to know you.

The PCP will check your medical history to help keep you healthy. This visit is covered as part of your preventive benefit. You need to see your PCP if you think you need hospital care that is not an emergency.

Your PCP must refer you if you need to see a specialist. Your PCP will give you a referral form. Take the form when you go to see the specialist. Make sure that the specialist is part of the SCI/UNMCI program. You can do this by calling Member Services. Don't get care without asking your PCP first. You may have to pay the bill if you do.

## **Care Coordination/Complex Medical Case Management**

Care Coordination/Complex Medical Case Management (CC/CMCM) is a benefit offered to Members with chronic or complex problems or special needs. The CC/CMCM program has nurses and other trained staff. They are skilled in different areas. They are there to help you with your care and to get the care you may need. They can help with

social issues. They know of agencies that may help you if a service is not covered.

If you have special health care needs you may be able to get CC/CMCM. Call Member Services for more information. You do not have to go through your PCP to get these services.

CC/CMCM work closely with you and your PCP and specialist. During their first call to you, an initial review is done to identify your needs. This review helps the CC/CMCM and the PCP and specialist to start a plan of care for you. The plan of care is developed with your input. The CC/CMCM then puts the plan of care into action. The CC/CMCM will coordinate the plan of care as your needs change.

### **What is Care Coordination?**

Care Coordination is a service available to all Members of Molina Healthcare. It may be of special help to Individuals with Special Health Care Needs. A Care Coordinator is a professional licensed nurse or social worker or other paraprofessional. They can help you in locating services. They can help you get through the health care system. They can help you get the services you need to ensure your good health. Below are some of the services offered by Care Coordination:

- Medical care;
- Emotional care;
- Social work;
- Nutrition programs;
- Food banks;
- Education agencies;
- Medical equipment;
- Medications;
- Tests or procedures; and
- Support groups.

### **Goals of Care Coordinators**

Care Coordinators are there to be your advocate. They respect your dignity as a human being. Care Coordinators:

- Support Members in their right to make their own decisions;
- Provide services that are sensitive to the cultural needs of Members;

- Will not impose personal values on Members;
- Support Members in becoming more independent;
- Allow the support systems and relationships of Members to be included in planning;
- Give Members care coordination that helps with needs and supports building personal strengths; and
- Give polite and courteous help at all times.

### **How Do I get Care Coordination?**

To get Care Coordination, call the Care Coordination Intake Specialist. Call them toll free at (800) 377-9594 ext. 181120. You may also call (505) 342-4660 ext. 181120. The Intake Specialist will ask you some questions. These questions will help the Intake Specialist. It will help them know if Care Coordination is a service that will be helpful to you.

### **When Do I call My Care Coordinator?**

Our normal hours of operations are Monday through Friday from 8:00 a.m. to 5:00 p.m. If you think you need emergency treatment, please get help first. Tell your Care Coordinator after you get care.

### **The Woman's Health & Cancer Rights Act**

SCI/UNMCI has some benefits for mastectomy-related medical conditions. This is part of the Women's Health and Cancer Rights Act of 1998. Call Member Services if you have questions.

## **HEALTH IMPROVEMENT SERVICES**

### **Staying Healthy**

We want to help you stay healthy. We have many health education programs. They cover topics such as:

- Asthma;
- Parenting;
- Diabetes;
- Nutrition;
- Pregnancy and car seat safety; and
- Quitting Smoking.

We offer a free Healthwise® Handbook. For a list of all classes and services, call the Health Improvement Hotline at (505) 342-4660, ext.182618. You can also call toll free at (800) 377-9594, ext. 182618.

## Disease Management Services

Molina Healthcare offers Disease Management services to you. We can help you if you have diabetes, asthma or heart disease. We can help you if you are pregnant.

Disease Management is focused on your care. You are assigned to a Care Manager who acts as an educator. He/she will help to improve the care you get from your practitioner/provider. The Care Manager will teach you about your disease. He/she will coordinate your care with your PCP and other resources.

For more information about Molina Healthcare's Disease Management Programs, call the Health Improvement Hotline at (505) 342-4660 ext. 182618. You can also call toll free at (800) 377-9594 ext. 182618.

## Breathe with Ease<sup>sm</sup> Asthma Program

Molina Healthcare has classes, booklets, peak flow meters and other services if you have asthma.

You can start taking control of your asthma by learning:

- What triggers your asthma;
- What you can do about asthma triggers;
- What you can do for asthma attacks;
- How to use your medicines; and
- How to make an asthma action plan with your practitioner/provider.

## Healthy Living<sup>TM</sup> with Diabetes

Molina Healthcare has classes, booklets and other services if you have diabetes. Diabetes is a common but serious disease. It makes it hard for your body to use food as energy. If you have diabetes, it is important for you to learn:

- What diabetes is and how it changes the way your body turns food into energy;
- How to control your diabetes with blood sugar

- monitoring, eating the right foods, exercising and taking medicines, if your PCP orders them;
- How to take care of your body and prepare for special situations;
- How to cope with your emotions; and
- Where to turn when you need support.

## motherhood matters<sup>sm</sup> Pregnancy Program

Molina Healthcare offers classes for pregnant Members. It is called the motherhood matters<sup>sm</sup> Pregnancy Program. Molina Healthcare cares about the health of our pregnant Members.

## Quit For Life<sup>®</sup> Tobacco Cessation Program

Molina Healthcare Members who are ready to quit smoking can get help. The *Quit For Life*<sup>®</sup> Program from *Free and Clear* is available. It will help you quit tobacco and stay healthy. A quit coach will help you make good decisions about medications. They will help you develop new thinking skills and learn how to act differently in situations that involve tobacco. They will help you stay quit. Call *Quit For Life*<sup>®</sup> at (866) QUIT-4-LIFE or (866) 784-8454. Or you can log on to [www.quitnow.net](http://www.quitnow.net).

## Preventive Health Guidelines

Preventive Health Guideline charts are included at the end of this handbook. They tell you when you should visit your practitioner/provider for preventive care. They let you know about the tests and care you should get during each visit. If you need help reading the charts, call the Health Improvement Hotline. You can call them at (505) 342-4660, ext. 182618. You can also call toll free at (800) 377-9594, ext. 182618.

## COVERAGE AND ELIGIBILITY

Your SCI/UNMCI eligibility is effective for a period of twelve (12) months. It is effective even if you have changes in your income. You have to renew your SCI eligibility every twelve (12) months with

the State Income Support Division (ISD) office. You can also do this by contacting the Patient Financial Services at UNMH.

You will no longer be covered by SCI/UNMCI if you:

- Lose your SCI/UNMCI coverage (such as qualifying for full Medicaid or Medicare benefits or other commercial insurance);
- Give wrong information on your enrollment form;
- Reach your benefit maximum of \$100,000 or 25 inpatient bed days;
- Move out of the coverage area; or
- Fail to renew your coverage every twelve (12) months.

## Switching Managed Care Organizations (MCOs)

You can ask to switch to another MCO. You can do this at renewal or recertification of your SCI eligibility with the ISD office. At any other time you can switch to another MCO only “for cause” as defined by HSD. You must ask for this switch in writing. Make your request to HSD.

Send your written request to:

Client Services Bureau  
HSD/MAD  
P.O. Box 2348  
Santa Fe, NM 87504-2348

Or fax to: (505) 476-6825

You should include the following information:

- Tell us that you are enrolled in SCI/UNMCI;
- The name of the MCO you want to switch to;
- Your name, social security number and identification number;
- Your full mailing address and telephone number;
- The reason for the change – if it involves a doctor, you need to give the doctor’s name and telephone number in the letter; and
- Your signature.

HSD will mail a written response to you and Molina Healthcare within thirty (30) calendar days if the MCO switch is approved. The change will be effective when you complete the enrollment process

with the new MCO. You will need to get your claims balance from Molina Healthcare in writing at the time you switch. You will need to give the claims balance information to your new MCO.

HSD 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 fair hearing.

If you are enrolled through an employer, you can switch health plans if:

- Your employer switches health plans. You will switch to the employers new health plan unless you choose to switch to an Individual SCI plan; or
- You change employers and your new employer does not offer SCI coverage with your current health plan.

## Disenrollment

You have the right to disenroll from SCI/UNMCI at any time. If you want to disenroll from SCI/UNMCI, it is considered a voluntary drop of coverage. If you voluntarily drop your SCI/UNMCI coverage you won’t be eligible to re-enroll for SCI/UNMCI coverage for six (6) months. The six (6) month period starts with the first month your coverage was dropped. You will have to reapply through HSD. You must pay any past due premiums before you can be re-enrolled in the SCI/UNMCI program

## How to Keep Getting Care

You will lose your coverage for the remainder of the benefit period if you reach your benefit maximum of \$100,000. Molina Healthcare and University of New Mexico Hospital (UNMH) will work together to try to move you to another health program.

## Renewing Your Coverage

Every twelve (12) months you will need to renew in the SCI/UNMCI program. Call UNMH Patient Financial Services at (505) 272-2521 to make an appointment. If you have questions you can call Member Services.

## Other Insurance Coverage

Call Molina Healthcare Member Services to tell us if you:

- Have medical insurance through your workplace;
- Have been hurt at work or have a worker's injury claim;
- Are in a car accident;
- Have filed a medical malpractice lawsuit or personal injury claim; or
- Have other coverage or insurance.

## Out-Of-Pocket Costs for Members

Out-of-Pocket costs for all Members will be limited to five percent (5%) of the maximum countable family income per benefit year. This amount is based on the family income provided during the enrollment process. This amount appears in your Notice of SCI Eligibility letter. The letter is from the NM Income Support Division.

It is the job of each Member to track co-payments for covered benefits. The co-payments count for your out-of-pocket payments. The amounts should be tracked by benefit year.

The Member must tell Member Services when the maximum out-of-pocket has been met. The Member must give proof of the paid amounts. When the paid amounts have been checked, the Member will not owe any more co-payments for the rest of that benefit year.

The first month that co-payments are not needed by the Member is the month following the month in which it was checked by Molina Healthcare that the maximum out-of-pocket amount has been met. If it is verified after the twenty-fourth (24th) of the month, the change is effective the second month after the verification. No retro-active eligibility for "met" amounts will be allowed.

## CONSUMER ADVISORY BOARD

Molina Healthcare has a Consumer Advisory Board (CAB). The CAB has SCI/UNMCI Members,

providers and advocacy groups. They help us understand some of the issues facing our SCI/UNMCI Members. One of the things the CAB does is find ways to make sure all Members get the health care they need.

The Molina Healthcare CAB works hard to improve Member and provider satisfaction. This includes the satisfaction of advocacy groups. The CAB members give ideas to Molina Healthcare. Ideas can be about such things as customer service, quality improvement, member education and outreach materials or other aspects of the plan's daily operations. Molina Healthcare looks at these ideas. We put the ideas into place when it is the right thing to do.

Molina Healthcare has CAB meetings every three (3) months. Molina Healthcare wants Members to be a part of the CAB. Call Member Services if you want to join. You can call Member Services if you have ideas for the CAB to consider.

## YOUR PRIVACY

Your privacy is important to us. We respect and protect your privacy. Molina Healthcare uses and shares your information to provide you with health benefits. Molina Healthcare wants to let you know how we may share or use your information.

"PHI" means "protected health information." PHI is your health information that includes your name, member number or other things that can be used to identify you, and is used or shared by Molina Healthcare.

### Why does Molina Healthcare use or share our Members' PHI?

- To provide your health care;
- 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; and
- To use or share PHI for other purposes as required or permitted by law.

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

Molina Healthcare needs your written approval to use or share your PHI for purposes not listed above.

### **What are your privacy rights?**

- To look at your PHI;
- To get a copy of your PHI;
- To amend your PHI;
- To ask us to not use or share your PHI in certain ways; and
- To ask for a list of certain people or places we have given your PHI.

### **How does Molina Healthcare protect your PHI?**

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word or PHI in a computer. Below are some ways Molina Healthcare protects PHI. Molina Healthcare:

- Has policies and rules to protect PHI;
- Limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use and share PHI;
- Staff is trained on how to protect and secure PHI;
- Staff must agree in writing to follow the rules and policies that protect and secure PHI; and
- Secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

### **What can you do if you feel your privacy rights have not been protected?**

- Call or write Molina Healthcare and file a complaint; or
- File a complaint with the U.S. Department of Health and Human Services.

The above is only a brief summary. Our Notice of Privacy Practices has more details about how we use and share our Members' PHI. Our Notice of Privacy

Practices is included in your New Member Packet and is on our web site. You may also call Member Services and ask for a copy of our Notice of Privacy Practices.

## **COMPLAINTS, APPEALS AND GRIEVANCES**

### **When You May Have to Pay for Other Charges**

There may be times when Molina Healthcare may not pay a bill from a practitioner/provider. This may be because the service is not covered.

If Molina Healthcare does not pay the bill, the practitioner/provider may send the bill to you.

They may send you the bill if:

- You did not show your SCI/UNMCI ID card when you received the service;
- You saw a practitioner/provider who is not part of the SCI/UNMCI program and the practitioner/provider did not get an approval; or
- You agreed in writing to pay for the service, before the service was provided.

If you think the practitioner/provider sent the bill to you by mistake, you have ninety (90) days to file an appeal. You can file your appeal with the Molina Healthcare Appeals Department. You can call or write to file a complaint or appeal.

Molina Healthcare  
Attn: Appeals Department  
P.O. Box 3887  
Albuquerque, NM 87190-9859  
Toll free: (800) 723-7762

### **How Complaints and Appeals Work**

You have the right to file a complaint or appeal. You can do this through the Molina Healthcare complaint/appeal process.

A complaint, also called a grievance, is an oral or written statement. You can make a complaint by saying you are unhappy about a part of Molina Healthcare or its operations.

An appeal is an oral or written request for review or reconsideration of a Molina Healthcare action. This can be related to limiting or denying approval for a requested service. This can be related to not paying for a service.

An expedited appeal is for certain situations. These are situations that can endanger your health. If we decide the normal appeal review time might harm your life or health, an expedited review will take place within seventy-two (72) hours of us getting the request.

## **How to File a Complaint, Appeal or Expedited Appeal**

Complaints and appeals may be requested orally or in writing. You can call the complaint and appeal numbers. They are available twenty-four (24) hours a day, seven (7) days a week:

In Albuquerque: (505) 342-4663  
Toll Free: (800) 723-7762

You can write to us at:

Molina Healthcare of New Mexico  
ATTN: Appeals Department  
P.O. Box 3887  
Albuquerque, NM 87190-9859

You can fax to us at: (505) 342-0583  
ATTN: Appeals Department

## **Who Can File a Complaint or Appeal?**

A complaint or appeal may be filed by you or:

- A legal guardian if you are incapacitated;
- A representative of your choice with your written consent; or
- Your practitioner/provider with your written consent.

You can speak for yourself in a complaint, appeal or Fair Hearing. You have the right to have legal counsel. You have the right to have another spokesperson. You must pay the costs of being represented. Molina Healthcare will let you, your representative, or your estate representative be parties to an appeal.

Filing a complaint or appeal will not change the way you are treated. Asking for a Fair Hearing will not change the way Molina Healthcare, SCI/UNMCI practitioners/providers, or the Human Services Department (HSD) treats you.

All information about your complaint or appeal is private. This includes your status as a grievant. We do not give out your information about a complaint. We can't do this without your written permission, unless we are required to by law. The filing limit for asking for a complaint or appeal is ninety (90) calendar days. This is from the date of occurrence.

Molina Healthcare wants to give you the best possible care. Call Member Services if you are having problems. We want to help fix the problem. Member Services can help you if you need help in another language.

The Appeals Department can help you through the complaint process. We try to fix issues as fast as we can. Let us know if you need help making a written request. We can help you.

Within five (5) working days after we get the request, Molina Healthcare will give you written notice that the complaint/appeal was received. The notice will include the date Molina Healthcare expects to resolve the complaint/appeal. It will have information on the complaint/appeal process. You and/or your representative can look at the case file before and during the appeal process. This includes medical records and other documents used during the appeal process that are not confidential or privileged information.

A health care professional with suitable clinical experience will take part in the review of medically related complaints and/or appeals. Formal complaints and/or appeals are generally resolved within thirty (30) calendar days. We will ask for more time if it is needed. An extension of up to fourteen (14) calendar days can be given if you ask for it. An extension can be granted by the Human Services Department (HSD) to Molina Healthcare. We will tell you if there is a delay.

A written decision will be made for all formal

complaint and appeal requests. The written response for a complaint will include but is not limited to:

- The reason for the complaint;
- All information used in the investigation;
- Findings and conclusions based on the investigation; and
- The outcome of the complaint.

The written response for an appeal will include, but is not limited to:

- The reason for the appeal;
- The result of the appeal resolution; and
- The date the appeal was completed.

If the appeal results in a continued denial, the written notice will include:

- The reason for the action being taken by Molina Healthcare;
- Specific references and citations supporting the decision as taken from Medical Assistance Division (MAD) and/or Molina Healthcare policies and procedures;
- The next appeal review process available to you through Molina Healthcare or HSD (for appeal issues) if you are not happy with the decision. This information will include Molina Healthcare's internal hearing process as applicable;
- Information on your right to ask for an Administrative Fair Hearing of an appeal denial within ninety (90) calendar days of the decision. You are not responsible for the cost of an Administrative Fair Hearing through HSD;
- The right to ask for benefits while the hearing is pending. We will let you know how to ask for this; and
- Information that you may have to pay for the cost of continuing to get benefits. This is if the hearing decision upholds Molina Healthcare's denial decision.

You can ask for an internal hearing if you are not happy with Molina Healthcare's first appeal decision. You can ask for a final internal review. You must do this within ninety (90) calendar days from the date you are told about the appeal denial. We will call you to schedule the internal hearing. Review by an internal hearing committee does not apply for

most complaints, such as when you complain that the practitioner/provider was "rude". Follow-up and possible corrective actions may be taken; however, there is no denial decision to appeal in this situation.

You and/or your representative are given a reasonable chance to present evidence, and allegations of fact or law. You can do this in person or in writing. You can do this throughout the appeal process.

Call Member Services if you have questions. You can ask for a detailed copy of the complaint and appeal process. You can get complaint and appeal information from our website. Visit [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

## **How to Request an HSD Administrative Hearing (Fair Hearing)**

You have a right to ask for an Administrative Hearing with HSD. You can do this only after you have exhausted the Molina Healthcare appeals process. You can do this when Molina Healthcare makes a decision to modify, change, terminate, suspend, reduce, deny payment for service, or deny your benefits. You do not have to pay for the cost of an Administrative Hearing. You and/or your spokesperson will work with Molina Healthcare in the Hearing.

You have a right to ask for an Administrative Hearing to appeal a Molina Healthcare decision to the HSD Hearings Bureau. You have to do this within ninety (90) calendar days of the final Molina Healthcare decision. You can contact HSD by writing or calling:

Human Services Department  
Hearings Bureau  
P.O. Box 2348  
Santa Fe, NM 87504-2348  
In Santa Fe: (505) 827-8164  
Toll free: (800) 432-6217, then press 6

If you ask for an Administrative Hearing directly to us, we will send it to HSD. Molina Healthcare can't ask for an Administrative Hearing for you. Your practitioner/provider can't ask for an Administrative Hearing for you. You must give your written consent.

Under some circumstances we will not discontinue your services until after a ruling from the hearing. Your request for an Administrative Hearing must be received by HSD within thirteen (13) calendar days from Molina Healthcare's final decision.

This doesn't require Molina Healthcare to start any treatment or services. This doesn't require Molina Healthcare to increase the level of current treatment or services. You will have to pay the cost of treatment or services you get while the Administrative Hearing was pending. You will have to pay the cost of services you get if the denial is upheld at the hearing.

If the request for an Administrative Hearing isn't received within thirteen (13) calendar days, Molina Healthcare may stop providing treatment or services related to the appeal. If you have met your claim benefit maximums (dollars or bed days or pharmacy for the month) or have not paid premiums or paid premiums late, you will not have continuation of benefits when requesting a hearing within thirteen (13) calendar days of the notice.

## **ANTI-FRAUD PROGRAM**

Health care fraud, waste and abuse are a major problem. They can make taxes go up. They can cause quality of care issues. Molina Healthcare works with state and federal agencies to detect, prevent and put a stop to these kinds of crimes.

State and federal laws require Molina Healthcare to report fraud, waste and abuse. Cases are sent to the government and/or law enforcement for investigation.

### **Why is it Important to Have an Anti-Fraud Program?**

Health care fraud, waste and abuse is against the law. The Anti-Fraud program looks at these issues. They can harm the SCI/UNMCI program. They can impact our ability to care for you.

The role of the Anti-Fraud program is to:

- Detect;
- Prevent;
- Investigate; and
- Report.

### **What is Fraud?**

Fraud is an unfair or unlawful act. Fraud is done on purpose to get something of worth.

### **What is Abuse?**

Abuse happens when things are not done in line with good financial, business or medical practices. This can result in unnecessary costs. This can result in payment for services that are not medically necessary. It can result in services that fail to meet professionally recognized standards for health care.

### **Who commits Fraud, Waste and Abuse?**

Anyone can commit fraud, waste or abuse. This includes providers and Members.

### **Provider Fraud, Waste and Abuse Examples**

- Altering claims or medical records in order to get a higher payment;
- Balance billing;
- Billing a procedure that does not match the diagnosis or problem;
- Billing for services that did not happen;
- Billing for services using a provider's name that did not provide care;
- False coding in order to get payment or get a higher payment;
- Charging Members for drug samples;
- Having Members come in for office visits more often than is needed;
- Questionable prescription practices;
- Questionable transportation services;
- Unbundling services in order to get more payment;
- Underutilization;

- Upcoding; or
- Waiving co-payments.

## Member Fraud, Waste and Abuse Examples

- Abusing transportation benefits (e.g. using ambulance services for non-emergencies);
- Doctor shopping in order to get services that are not needed;
- Drug seeking behavior;
- Drug trafficking;
- Forgery;
- Giving false information;
- Identity theft;
- Not paying co-payments;
- Not giving information to Molina Healthcare about other insurance coverage;
- Theft; or
- Using someone else's medical card.

## Reporting Fraud, Waste and Abuse

Anyone with information about possible fraud, waste and abuse can make a referral. Referrals are sent to the Anti-Fraud program. If you make a referral, you can do so without giving your name. Information reported to the Anti-Fraud program will remain confidential to the extent possible as allowed by law.

Molina Healthcare does not allow or tolerate retaliation against those, who in good faith, report potential fraud, waste and abuse to the Anti-Fraud program.

You may report suspicious activity. You can do this in writing or by phone.

Anti-Fraud Program Manager  
Molina Healthcare of New Mexico  
P.O. Box 3887  
Albuquerque, NM 87190-9859

mhn.compliance@molinahealthcare.com  
Toll free Compliance &  
Anti-Fraud Hotline: (800) 827-2973  
In Albuquerque: (505) 341-7469  
Toll free fax: (866) 472-4580

Give as much information as possible when making a referral. The Anti-Fraud program needs to know:

- Who is the suspect?
- What is the suspect's name?
- When did the possible fraud, waste and abuse happen?
- Where did the possible fraud, waste and abuse happen?
- Why do you think the possible fraud, waste and abuse happened?
- How did the possible fraud, waste and abuse happen?

The more detail you can give the Anti-Fraud program, the better the chances the issue will be successfully reviewed and resolved.

You can also report fraud, waste and abuse to:

Medical Assistance Division  
Quality Assurance Bureau  
P.O. Box 2348  
Santa Fe, NM 87504-2348  
NM Medicaid Fraud@state.nm.us  
Toll free: (888) 997-2583  
In Santa Fe: (505) 827-3100

Medicaid Fraud Control Unit  
111 Lomas NW, Suite 300  
Albuquerque, NM 87102  
Toll free: (800) 678-1508  
In Albuquerque: (505) 222-9000

New Mexico Human Services Department  
Office of Inspector General  
Toll free: (800) 228-4802  
In Albuquerque: (505) 827-8141  
HSDOIGFraud@state.nm.us

## DEFINITIONS

**Abuse:** Practitioner/provider practices that are not in agreement with good business or medical practices. This could result in unneeded costs to Medicaid. It could end up in payment for services that are not medically needed. It could cause services that do not meet recognized standards for

health care. Abuse also includes Member practices that result in unnecessary costs to Medicaid.

**Advance Directives:** Adult Members can make choices about their medical care. An advance directive form tells how the Member wants to be cared for while sick or in an emergency.

**Appeal:** An oral or written request for review or reconsideration of a Molina Healthcare action. This request can be for limiting or denying approval for a requested service or not paying for a service.

**Benefit Maximum:** The maximum number of visits, days and/or dollars allowed during the specific contract term.

**Complaint (also known as a grievance):** An oral or written statement about any aspect of Molina Healthcare or its operations. Complaints can be voiced or filed by a:

1. Member
2. A legal guardian for an incapacitated Member
3. Member's authorized representative as selected in writing
4. Provider or practitioner acting on behalf of the Member with the Member's written consent

**Co-Payment:** The Member's share of costs for covered services. The amount is usually paid to the attending provider at the time care is given. There are specific co-payment amounts that apply to covered services. These are listed in the Member Handbook.

**Covered Services (Benefits):** The benefits offered in the SCI/UNMCI program by the State of New Mexico Human Services Department (HSD).

**Durable Medical Equipment (DME):** Equipment that is:

1. Primarily and commonly used to serve a medical purpose
2. Designed for repeated use

This equipment is necessary to provide mechanical substitution or assistance to the Member. It will help prevent further worsening of the Member's medical condition. It is not ordinarily useful to

a person without illness or injury. DME includes items such as wheelchairs, hospital beds, oxygen and oxygen supplies.

**Emergency Health Services:** Health care procedures, treatment, or services given to a Member after the sudden start of what appears to be a medical condition that is noticeable by severe signs including severe pain. A condition that without immediate medical care could reasonably be expected by a layperson to result in:

1. Threat to the Member's health
2. Serious injury of bodily functions, organ or part
3. Disfigurement to the Member

**Family Planning:** Health education that helps you make the right choices about birth control.

**Fraud:** An act done on purpose by a person or thing. This act is done knowing that it could result in an unlawful gain or benefit.

**Grievance (also known as a complaint):** See Complaint

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

**Hospital:** An eligible, licensed and approved acute care facility.

**Human Services Department (HSD):** The official department in New Mexico responsible for overseeing the Medicaid Program. HSD may also indicate the department's designee (Molina Healthcare).

**Identification Card (ID):** A card issued to a Member. The card is issued when approval is given by SCI/UNMCI. This card contains important information about your SCI/UNMCI coverage.

**Inpatient:** A Member who is confined for twenty-four (24) hours or more in a hospital.

**Managed Care Organization (MCO):** A company that offers or arranges basic health care services to Members on a pre-paid basis.

**Medical Director:** The physician employed by

Molina Healthcare to serve as the Medical Director of the Plan.

**Medically Necessary:** Clinical and rehabilitative physical or behavioral health services that:

1. Are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the individual to attain, maintain or regain functional capacity
2. Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral care needs of the individual
3. Are provided within professionally accepted standards of practice and national guidelines
4. Are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, provider, practitioner or payer

**Member:** A person enrolled in the SCI/UNMCI program.

**Member Responsibilities:** Your responsibilities as a Molina Healthcare Member.

**Member Rights:** Your rights as a Molina Healthcare Member.

**Molina Healthcare:** Molina Healthcare of New Mexico, Inc. A Corporation organized under the laws of the State of New Mexico.

**Non-Participating Provider:** A provider who has not contracted with SCI/UNMCI.

**Non-Covered Benefits (services):** Services that are not covered. The Member may have to pay the bill.

**Out of Pocket:** The amount a Member may have to pay a practitioner/provider for a service. This amount is separate from the payment Molina Healthcare may pay.

**Outpatient:** Medical services provided to a Member. These services take less than twenty-four (24) hours.

**Preventive Care:** Health services focusing on avoiding illness, disease and serious injury. These

services can include immunizations, screening or other health maintenance programs.

**Primary Care Practitioner (PCP):** An individual, such as a physician or other qualified practitioner, who provides primary care services (including family practice, general practice and internal medicine) and manages routine health care needs.

**Provider:** An institution or organization that provides services for MCO members. Examples of providers include hospitals and home health agencies.

**Prior Approval (authorization):** The process to receive an approval before a Member can get certain covered services.

**Referral:** When your PCP sends you to see another practitioner/provider for care.

**SCI/UNMCI Provider:** A practitioner or provider contracted with SCI/UNMCI to provide services.

**Second Opinion:** When you or your PCP requests another practitioner(s)/provider(s) opinion of your illness or condition.

**Service Area:** The SCI/UNMCI coverage area as defined by HSD.

**Transplant:** Surgery performed to transfer a body organ and/or tissue from a Donor to a Recipient.

**Urgent Care Services:** Medically necessary 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 of the Member's health.

# Preventive Health Guidelines for Adults

	21	25	30	35	40	45	50	55	60	65	70	75+
<b>SCREENING</b>												
Alcohol Use/Substance Abuse and Tobacco Use	First doctor visit. Discuss re-screening frequency with your doctor. At least every 2 years - more often if at risk.											
Blood Pressure	Discuss with your doctor which of the following tests work best for you: Yearly Every 3 to 5 years Every 10 years											
<b>COLORECTAL (INTESTINE) CANCER</b> Fecal Occult Blood Test (FOBT), Sigmoidoscopy or Colonoscopy	First doctor visit. Discuss re-screening frequency with your doctor. Yearly											
Depression	At risk only. Discuss with your doctor.											
Obesity (Height & Weight)	At risk only. Discuss with your doctor.											
Tuberculosis	Discuss needs with your doctor.											
Type 2 Diabetes												
Vision and Hearing												
<b>WOMEN</b>												
Breast Cancer (Mammography)	Every 1 to 2 years											
Cervical Cancer (Pap Smear)	Every 1 to 3 years as recommended by your doctor.											
Chlamydia (an STD that can lead to infertility)	Yearly - All sexually active women, age 25 years and younger and other women at risk. Discuss with your doctor. At least every 5 years											
Cholesterol	For women of childbearing age.											
Rubella blood test												
<b>MEN</b>												
<b>IMMUNIZATIONS</b>	At least every 5 years											
Influenza (Flu)	Yearly - At risk only. Discuss with your doctor.											
Pneumococcal	Yearly											
Tetanus-Diphtheria	Once											
Varicella (Chicken Pox)	Every 10 Years At risk only. Discuss with your doctor.											
<b>COUNSELING - Your doctor can help you improve your health by providing advice on topics such as:</b>												
Bicycle, motorcycle, skate board and ATV helmet use	Unintended pregnancy											
Dental health	Household, recreational, and motor vehicle injuries											
Family planning	Parenting skills											
Healthy diet	Stress management											
Menopausal health (women) including osteoporosis and heart disease	Sexually Transmitted Disease (STD) and HIV infection											
These recommendations are intended to be guidelines. In some cases, it may be necessary to tailor the recommendations to meet the needs of the patient and their individual situation.												
Sources: 1) Report of the U.S. Preventive Task Force, "Guide to Clinical Preventive Services", 3rd Edition, 2003; 2) State of New Mexico Medical Assistance Division, New Mexico Administrative Code 8.305.16, "Standards For Preventive Health Services".												
(revised 7/04)												

# Normas Preventivas para la Salud de los Adultos

	21	25	30	35	40	45	50	55	60	65	70	75+
<b>PRUEBA</b>												
Abuso del Alcohol y de las Substancias Adictivas y Uso de Tabaco												
Presión Arterial												
<b>CÁNCER COLORECTAL (INTESTINAL)</b>												
Prueba de Sangre Oculta en la Materia Fecal												
Sigmoidoscopia o Colonoscopia												
Depresión												
Obesidad (Estatura y Peso)												
Tuberculosis												
Diabetes de Tipo Dos												
Vista y Oído												
<b>MUJERES</b>												
Cáncer del Seno (Mamografía)												
Cáncer Cervical (Prueba "Pap")												
Clamidia (una enfermedad transmitida sexualmente que puede llevar a la infertilidad)												
Colesterol												
Prueba de sangre para detectar la Rubeola												
<b>HOMBRES</b>												
<b>VACUNAS</b>												
Influenza (gripe)												
Neumococo												
Tétano y Difteria												
Varicela (Viruela Loca)												
<b>CONSEJOS: Su médico le puede ayudar a mejorar su salud, proporcionándole consejos sobre lo que aparece a continuación:</b>												
Uso de cascos para andar en bicicleta, motocicleta, patineta y en vehículos para todos los terrenos												
Salud dental												
Planificación familiar												
Una dieta saludable												
Salud durante la menopausia (mujeres) incluso la osteoporosis y las enfermedades cardíacas												
Estas recomendaciones son solamente normas. En algunos casos, tal vez sea necesario modificar las recomendaciones para satisfacer las necesidades del paciente o de su situación especial.												
Fuentes de información: 1) Informe del Grupo de Trabajo para los Asuntos Preventivos de los EE.UU. ["Report of the U.S. Preventive Task Force"], Guía de Servicios Clínicos Preventivos ["Guide to Clinical Preventive Services"], Tercera Edición, 2003; 2) División de Ayuda Médica del Estado de Nuevo México ["State of New Mexico Medical Assistance Division"], Código Administrativo de Nuevo México 8.305.16, Normas de los Servicios Preventivos para la Salud ["Standards For Preventive Health Services"] (que fue modificado el 7/04).												

# Preventive Health Guidelines for Pregnancy

	Preconception	6-8 Weeks	14-16 Weeks	24-28 Weeks	32 Weeks	36 Weeks	38 Weeks	39 Weeks	40 Weeks	41 Weeks	Postpartum <sup>1</sup>
<b>HISTORY</b>											
Medical	•										
Psychosocial	•										
Update Medical/Psychosocial		•	•	•	•	•	•	•	•	•	•
<b>PHYSICAL EXAM</b>											
General	•										
Blood Pressure/Pulse	•	•	•	•	•	•	•	•	•	•	•
Height	•										
Weight	•	•	•	•	•	•	•	•	•	•	•
Height/Weight Profile	•										
Pelvic Exam/Pelvimetry	•	•									
Breast Exam	•	•									
Fundal Height		•	•	•	•	•	•	•	•	•	•
Fetal Position/Heart Rate			•	•	•	•	•	•	•	•	•
Cervical Exam											
Postpartum Visit 3-8 weeks After Delivery											•
<b>LAB TESTS</b>											
Hemoglobin or Hematocrit	•	•		•							•
RH Factor	•										
Pap Smear	•										
Diabetic Screen				•							
MSAFP			•								
Urine Dipstick	•										
Protein	•										
Sugar	•										
Urine Culture		•									
Infections											
Rubella Titer	•										•
Anti-D Immune Globulin											•
Syphilis Test	•										
Gonococcal Culture	•										
Hepatitis B	•										
HIV	•										
Strep B						•					
Illicit Drug Screen	•										
<b>INFLUENZA<sup>2</sup></b>			•	•	•	•	•	•	•	•	•
<b>RISK ASSESSMENT*</b>	•	•	•	•	•	•	•	•	•	•	•
<b>HEALTH PROMOTION*</b>	•	•	•	•	•	•	•	•	•	•	•

\*See companion chart listing guidelines for Risk Assessment and Health Promotion

<sup>1</sup>Guidelines For Prenatal Care, 3<sup>rd</sup> Edition, American Academy of Pediatrics & The American College of Obstetrics and Gynecology, October, 2002.

<sup>2</sup>The Advisory Committee for Immunization Practices (ACIP) recommends that pregnant women in their second or third trimester during influenza season should be vaccinated (December 2003).

(Revised 7/04)

Adapted from "Caring for Our Future: The Content of Prenatal Care - A report of the Public Health Service Expert Panel on the Content of Prenatal Care, 1987; Public Health Service Department of Health and Human Services"

# Normas Preventivas para la Salud durante el Embarazo

	Pre-concepción	De 6 a 8 Semanas	De 14 a 16 Semanas	De 24 a 28 Semanas	32 Semanas	36 Semanas	38 Semanas	39 Semanas	40 Semanas	41 Semanas	Después del parto <sup>1</sup>
<b>ANTECEDENTES</b>											
Médica	•										
Psicosocial	•										
Poner al Día lo Médico y lo Psicosocial		•	•	•	•	•	•	•	•	•	•
<b>EXAMEN FÍSICOS</b>											
En General	•	•	•	•	•	•	•	•	•	•	•
Presión Arterial y Pulso	•	•	•	•	•	•	•	•	•	•	•
Estatura	•	•	•	•	•	•	•	•	•	•	•
Peso	•	•	•	•	•	•	•	•	•	•	•
Características Generales de Estatura y Peso	•	•	•	•	•	•	•	•	•	•	•
Examen Pélvico y Pelvimetría	•	•	•	•	•	•	•	•	•	•	•
Examen de los Senos	•	•	•	•	•	•	•	•	•	•	•
Medida del Fondo del Utero	•	•	•	•	•	•	•	•	•	•	•
Medida del Fondo del Utero de los Latidos del Corazón	•	•	•	•	•	•	•	•	•	•	•
Examen Cervical	•	•	•	•	•	•	•	•	•	•	•
Visita de Después del parto, de 3 a 8 Semanas después de Dar a Luz	•	•	•	•	•	•	•	•	•	•	•
<b>PRUEBAS DE LABORATORIO</b>											
Hemoglobina o Hematócrito	•	•	•	•	•	•	•	•	•	•	•
Factor RH	•	•	•	•	•	•	•	•	•	•	•
Prueba del Cáncer Cervical [“Pap Smear”]	•	•	•	•	•	•	•	•	•	•	•
Examen de Detección Diabética	•	•	•	•	•	•	•	•	•	•	•
MSAFP	•	•	•	•	•	•	•	•	•	•	•
Prueba de la Orina con Tiro Reactiva	•	•	•	•	•	•	•	•	•	•	•
Proteína	•	•	•	•	•	•	•	•	•	•	•
Azúcar	•	•	•	•	•	•	•	•	•	•	•
Urocultivo	•	•	•	•	•	•	•	•	•	•	•
Infecciones	•	•	•	•	•	•	•	•	•	•	•
Concentración de Rubéola	•	•	•	•	•	•	•	•	•	•	•
Globulina de Inmunidad Anti-D	•	•	•	•	•	•	•	•	•	•	•
Prueba de Sífilis	•	•	•	•	•	•	•	•	•	•	•
Cultivo Gonococal	•	•	•	•	•	•	•	•	•	•	•
Hepatitis B	•	•	•	•	•	•	•	•	•	•	•
VIH	•	•	•	•	•	•	•	•	•	•	•
Estreptococo B	•	•	•	•	•	•	•	•	•	•	•
Examen de Detección de Drogas Ilícitas	•	•	•	•	•	•	•	•	•	•	•
<b>INFLUENZA<sup>2</sup></b>	•	•	•	•	•	•	•	•	•	•	•
<b>PROMOCIÓN DE LA SALUD<sup>3</sup></b>	•	•	•	•	•	•	•	•	•	•	•

\* Refiérase a la tabla acompañante que enumera las normas para la "Evaluación de los Riesgos y la Promoción de la Salud"

<sup>1</sup> Normas para la Atención Perinatal [“Guidelines For Perinatal Care”], 5a Edición, Academia Americana de Pediatría y Colegio Americano de Obstetricia y Ginecología, octubre de 2002

<sup>2</sup> El Comité Consultivo de las Prácticas de Inmunización (CCPI) recomienda que las mujeres en su segundo o tercer trimestre de embarazo se vacunen durante la temporada de la gripe o influenza (diciembre de 2003).

(Revisado y ampliado 7/04)

Adaptado de "Caring for Our Future: The Content of Prenatal Care - A report of the Public Health Service Expert Panel on the Content of Prenatal Care," [Cuidando Nuestro Futuro: El Contenido del Cuidado Prenatal: Un Informe del Panel de Expertos sobre el Servicio de la Salud Pública referente al Cuidado Prenatal] 1989; Oficina del Servicio de la Salud Pública, Departamento de Servicios Humanos y de Salud

<p><b>Risk Assessment Activities</b> History</p>	<p><b>Preconception or First Pregnancy Visit</b></p> <ul style="list-style-type: none"> <li>• Socio-demographic</li> <li>• Psychological</li> <li>• Menstrual/gynecologic</li> <li>• Contraceptive and sexual</li> <li>• Past obstetric</li> <li>• Medical and surgical</li> <li>• Genetic - Individual, spouse, and family</li> <li>• Nutrition</li> <li>• Behavioral</li> <li>• Environmental and/or work hazards</li> <li>• Current pregnancy to date</li> </ul>	<p><b>Routine Prenatal Visit</b></p> <ul style="list-style-type: none"> <li>• Pregnancy history to date</li> <li>• Problems or danger signs since last visit</li> <li>• Ability to follow recommendations or treatments</li> </ul>	<p><b>Routine Postpartum Care</b></p> <ul style="list-style-type: none"> <li>• Update physical and psychosocial status of mother and newborn</li> </ul>
<p><b>Physical Exam</b></p>	<ul style="list-style-type: none"> <li>• General appearance and nutrition</li> <li>• Blood pressure, pulse</li> <li>• Height to weight profile, present weight</li> <li>• Head and neck</li> <li>• Heart and lungs</li> <li>• Breasts</li> <li>• Abdomen</li> <li>• Pelvic area tenderness</li> <li>• Extremities and back</li> <li>• Neuromuscular</li> <li>• Pelvic exam</li> </ul>	<ul style="list-style-type: none"> <li>• General appearance and nutrition</li> <li>• Blood pressure</li> <li>• Weight, including pattern of weight gain</li> <li>• Abdominal assessment (see fetal evaluation)</li> <li>• Cervical check after 40 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule postpartum visit with health care practitioner 3 – 8 weeks after delivery</li> <li>• Height/Weight Profile</li> <li>• Pelvic Exam/Pelvimetry</li> <li>• Breast Exam</li> <li>• Cervical Exam</li> </ul>
<p><b>Lab Tests</b></p>	<ul style="list-style-type: none"> <li>• Hemoglobin or hematocrit</li> <li>• Blood Rh, Rh negative titer, antibody screen</li> <li>• Rubella titer</li> <li>• Serology</li> <li>• Pap smear</li> <li>• Urine protein and glucose</li> <li>• Urine screen for urinary tract infection, kidney disease</li> <li>• Gonorrheal smear</li> <li>• Hepatitis B titer</li> <li>• HIV titer</li> <li>• Drug toxicology</li> <li>• Screening as indicated for toxoplasmosis tuberculosis, herpes simplex varicella, chlamydia, hemoglobinopathies, Tay Sachs</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal serum alpha-fetoprotein</li> <li>• Repeat hematocrit or hemoglobin</li> <li>• Diabetes screen</li> <li>• Serology</li> <li>• Other tests on indication</li> </ul>	<ul style="list-style-type: none"> <li>• Rubella vaccine if susceptible to rubella virus infection</li> <li>• Postpartum measurement of hemoglobin or hematocrit</li> <li>• ABO blood group and Rh D type are known, and if indicated, the appropriate amount of anti-D immune globulin administered</li> </ul>
<p><b>Fetal Evaluation</b></p>	<ul style="list-style-type: none"> <li>• Confirm gestational age (LMP, uterine size)</li> <li>• Auscultation of fetal heart after 8 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm gestational age</li> <li>• Fundal height measurements for fetal growth</li> <li>• Fetal lie, position, presentation, weight as term approaches</li> </ul>	
<p><b>Health Promotion Activities</b> Counseling to Promote and Support Healthful Behaviors</p> <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Smoking cessation</li> <li>• Avoidance of alcohol</li> <li>• Importance of folic acid</li> <li>• Avoidance of illicit drugs</li> <li>• Avoidance of teratogens</li> <li>• Safer sex</li> </ul>		<ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Avoidance of teratogens</li> <li>• Maternal seatbelt use</li> <li>• Safer sex</li> <li>• Support for smoking cessation</li> <li>• Work counseling</li> </ul>	<ul style="list-style-type: none"> <li>• Postpartum counseling</li> <li>• Postpartum activity and exercise</li> <li>• Common postpartum discomforts and relief measures</li> <li>• Nutrition counseling especially if breastfeeding</li> <li>• Postpartum depression                             <ul style="list-style-type: none"> <li>* Administer Postpartum Depression screening tool if indicated</li> </ul> </li> <li>• Newborn care counseling                             <ul style="list-style-type: none"> <li>• Infant car seat use</li> <li>• Bathing newborns</li> <li>• Care of umbilical cord</li> <li>• Family support upon discharge</li> <li>• Family planning</li> </ul> </li> </ul>

Actividades de la Evaluación de los Riesgos Antecedentes	Preconcepción o Primera Visita durante el Embarazo	Visita Prenatal Rutinaria	Atención Rutinaria después del Parto
	<ul style="list-style-type: none"> <li>• Sociodemográfica</li> <li>• Psicológica</li> <li>• Menstrual/ginecológica</li> <li>• Anticonceptiva y sexual</li> <li>• Posobstétrica</li> <li>• Médica y quirúrgica</li> <li>• Genética: Individual, conyugal y familiar</li> <li>• Nutrición</li> <li>• Del Comportamiento</li> <li>• Ambiental y/o peligros en el trabajo</li> <li>• Embarazo actual hasta la fecha</li> </ul>	<ul style="list-style-type: none"> <li>• Antecedentes de embarazos: hasta la fecha</li> <li>• Problemas o señales de peligro desde la última visita</li> <li>• Habilidad para seguir recomendaciones y tratamientos</li> </ul>	<ul style="list-style-type: none"> <li>• Poner al día el estado físico y psicosocial de la madre y del recién nacido</li> </ul>
<p><b>Examen Físico</b></p>	<ul style="list-style-type: none"> <li>• Nutrición y apariencia general</li> <li>• Presión Arterial, pulso</li> <li>• Perfil de altura y peso; peso actual</li> <li>• Cabeza y cuello</li> <li>• Corazón y pulmones</li> <li>• Senos</li> <li>• Abdomen</li> <li>• Sensibilidad en el área pélvica</li> <li>• Extremidades y espalda</li> <li>• Neuromuscular</li> <li>• Examen Pélvico</li> </ul>	<ul style="list-style-type: none"> <li>• Nutrición y apariencia general</li> <li>• Presión Arterial, pulso</li> <li>• Peso, incluyendo el patrón del aumento de peso</li> <li>• Evaluación del abdomen (Vea la evaluación del feto)</li> <li>• Examen de la cerviz después de las 40 semanas</li> </ul>	<ul style="list-style-type: none"> <li>• Programar una visita después del parto con un profesional médico de 3 a 8 semanas después de dar a luz</li> <li>• Características Generales de Estatura y Peso</li> <li>• Examen Pélvico y Pelvimetría</li> <li>• Examen de los Senos</li> <li>• Examen Cervical</li> </ul>
<p><b>Pruebas de Laboratorio</b></p>	<ul style="list-style-type: none"> <li>• Hemoglobina o Hematócrito</li> <li>• Rh en la sangre, factor negativo de Rh, prueba de anticuerpos</li> <li>• Factor de la Rubéola</li> <li>• Serología</li> <li>• "Pap Smear" (prueba del cáncer en la cerviz)</li> <li>• Prueba de proteína y glucosa en la sangre</li> <li>• Prueba de gonorrea</li> <li>• Prueba de la orina para la infección del tracto urinario y para la enfermedad de los riñones</li> <li>• Título de Hepatitis B</li> <li>• Título de la VIH</li> <li>• Toxicología de las drogas</li> <li>• Pruebas según sean indicadas para toxoplasmosis, tuberculosis, herpes simple, varicela, clamidia, enfermedades en la hemoglobina y Iay Sachs</li> </ul>	<ul style="list-style-type: none"> <li>• Feto-alta proteína y suero materno</li> <li>• Repetir la prueba de hemoglobina o hematócrito</li> <li>• Prueba de la diabetes</li> <li>• Serología</li> <li>• Otras pruebas según sean indicadas</li> </ul>	<ul style="list-style-type: none"> <li>• Vacuna de rubéola, si es susceptible a la infección del virus de la rubéola después</li> <li>• Medida de la hemoglobina o del hematócrito del parto</li> <li>• Si se conocen y se indican el tipo de Rh D y el grupo ABO de la sangre, se administra la cantidad de globulina de inmunidad anti-D</li> </ul>
<p><b>Evaluación del Feto</b></p>	<ul style="list-style-type: none"> <li>• Confirmar la edad gestacional ("IIMP, tamaño del útero")</li> <li>• Auscultación del corazón del feto después de 8 semanas</li> </ul>	<ul style="list-style-type: none"> <li>• Confirmar el tiempo de la gestación</li> <li>• Medidas de la altura fúndica para el crecimiento fetal</li> <li>• Cómo está acostado el feto, su posición, presentación y el peso del mismo, al acercarse el final del tiempo de gestación</li> </ul>	<ul style="list-style-type: none"> <li>• Orientación después del parto</li> <li>• Actividades y ejercicios después del parto</li> <li>• Molestias comunes después del parto y métodos de alivio</li> <li>• Orientación sobre la nutrición, especialmente si la madre está alimentando al pecho materno, es decir, lactancia materna</li> <li>• Depresión después del parto</li> <li>• *Realizar el Examen de Detección de la Depresión después del Parto, si parece indicado</li> <li>• Orientación para atender al recién nacido</li> <li>• Cómo utilizar el asiento seguridad en los carros para los bebés</li> <li>• Cómo bañar a los recién nacidos</li> <li>• Cómo cuidar el cordón umbilical</li> <li>• Apoyo familiar al darle de alta</li> <li>• Planificación familiar</li> </ul>
<p><b>Actividades para el Fomento de la Salud</b> Orientación para Fomentar y Apoyar Bebés Saludables</p>	<ul style="list-style-type: none"> <li>• Nutrición</li> <li>• Dejar de fumar</li> <li>• Evitar el alcohol</li> <li>• Importancia del ácido fólico</li> <li>• Evitar las drogas ilícitas</li> <li>• Evitar los teratógenos</li> <li>• Relaciones sexuales más seguras</li> </ul>	<ul style="list-style-type: none"> <li>• Nutrición</li> <li>• Evitar los teratógenos</li> <li>• Utilización de los cinturones de seguridad por la madre</li> <li>• Relaciones sexuales más seguras</li> <li>• Apoyo para dejar de fumar</li> <li>• Consejos para el trabajo</li> </ul>	<ul style="list-style-type: none"> <li>• Orientación después del parto</li> <li>• Actividades y ejercicios después del parto</li> <li>• Molestias comunes después del parto y métodos de alivio</li> <li>• Orientación sobre la nutrición, especialmente si la madre está alimentando al pecho materno, es decir, lactancia materna</li> <li>• Depresión después del parto</li> <li>• *Realizar el Examen de Detección de la Depresión después del Parto, si parece indicado</li> <li>• Orientación para atender al recién nacido</li> <li>• Cómo utilizar el asiento seguridad en los carros para los bebés</li> <li>• Cómo bañar a los recién nacidos</li> <li>• Cómo cuidar el cordón umbilical</li> <li>• Apoyo familiar al darle de alta</li> <li>• Planificación familiar</li> </ul>



**PHARMACY MAIL SERVICES APPLICATION**  
PLEASE PRINT SO ALL INFORMATION IS LEGIBLE.

Date: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**NOTE: We must have a physical address and include apartment number. Someone must be home to receive the delivery. A post office box is not acceptable. Tell us right away if there is a change of address.**

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Work Phone #: \_\_\_\_\_



-----CUT HERE-----

MAIL TOP PORTION TO Outpatient Pharmacy, University Hospital, 1209 University Blvd. NE, Albuquerque, NM 87102. KEEP BOTTOM PORTION FOR YOUR RECORDS.

**GUIDELINES FOR MAIL SERVICE**

**1. ORDERING MEDICATIONS** - It is the responsibility of the patient or the patient's caregiver to order medications by calling the mailroom at (505) 272-8663.

- When leaving a message on the mailroom answering machine, remember to leave the following information: Patient name, medical record number, refill number, medication name, and telephone number.
- Remember to speak clear and slow.
- Do not use the automated refill system. It is not set up for pharmacy mail services.

**2. PAYMENTS** - We accept money orders and checks. Include your medical record number and NM Driver's License ID number.

- Make your check payable to UNMH Outpatient Pharmacy.
- Credit Card payments must be made in person at the pharmacy.

**3. OVERDUE BALANCES** - We will not mail any medications if a balance is more than thirty (30) days past due. You will be required to pick up medications at the pharmacy window and pay on the amount past due.

**4. FINANCIAL ASSISTANCE** - All patients must have current UNM Cares assistance or UNM SCI. Medicare patients must also have Medicare part D. If you need to apply for UNM assistance, call (505) 272-2521. If you are a Medicare patient and need to enroll in Medicare part D you can call (800) MEDICARE.

**5. DELIVERY** - PLEASE ALLOW TEN (10) WORKING DAYS TO PROCESS AND MAIL MEDICATIONS. This applies to new prescriptions and refills. UPS/USPS is allowed up to three (3) business days to deliver your shipment from the date shipped. They do not deliver on weekends or major holidays.

- We do not mail refrigerated medications (ex: insulin) on Friday's or during the summer months of April-September.
- We must have a physical address for delivery. A post office box is not acceptable. Tell us right away if there is a change of address.
- Someone must be home to receive the delivery.
- Address your envelope to:

Outpatient Pharmacy  
University Hospital  
1209 University Blvd., NE