MOLINA® HEALTHCARE

Health Insurance Marketplace = HIM
Special Needs Plan = SNP
Agency-Based Community Benefit = ABCB
Self-Directed Community Benefit = SDCB
Alternative Benefit Plan = ABP

MHNM Benefit Coverage for Centennial Care/Health Insurance MarketPlace/Options Plus/Medicare Options					
Benefit Name	**Centennial Care**	**CC ABP**	**HIM**	**Options Plus (SNP)**	**Options**
Federal Poverty Levels					
Accredited Residential Treatment Center Services (RTC)	X	N/C*	X	N/C	N/C
Adaptive Skills Building (Autism)	X	N/C*	X	N/C	N/C
Adult Day Health	ABCB	N/C*	N/C	N/C	N/C
Adult Psychological Rehabilitation Services	X	N/C*	N/C	N/C	N/C
Allergy testing and injections	X	X	X	N/C	N/C
Ambulance Services	X	X	X	X	X
Ambulatory Surgical Center Services	X	N/C*	X	X	X
Anesthesia Services	X	X	X	X	X
Assertive Community Treatment Services	X	N/C*	N/C	N/C	N/C
Assisted Living	ABCB	N/C*	N/C	N/C	N/C
Audilogy/hearing tests	X	X	X	X	X
Autism Spectrum Disorders	X	Limits	Limits	N/C	N/C
Bariatic surgery	N/C*	Limits	Limits	N/C	N/C
Behavior Support Consultation	ABCB/SDCB	N/C*	N/C	N/C	N/C
Behavior Management Skills Depelopment Services	X	N/C*	N/C	N/C	N/C
Behavioral Health Professional Services: Outpatient behavioral and substance abuse services	X	X	X	X	X

MHNM Benefit Coverage for Centennial Care/Health Insurance MarketPlace/Options Plus/Medicare Options					
Benefit Name	**Centennial Care**	**CC ABP**	**HIM**	**Options Plus (SNP)**	**Options**
Federal Poverty Levels					
Breast reconstruction following mastectomy	X	X	X	X	X
Cancer Clinical Trials	N/C*	X	X	Limits	Limits
Cardiac Rehab	X	Limits	X	X	X
Case Management	X	X	X	X	X
Chemotherapy Services	X	X	X	X	X
Cleft palate and cleft lip conditions	N/C*	X	X	N/C	N/C
Colorectal Cancer Screening	X	X	X	X	X
Community Transition Services	ABCB	N/C*	N/C	N/C	N/C
Community Interveners for the Deaf and Blind	X	N/C*	N/C	N/C	N/C
Comprehensive Community Support Services	X	N/C*	N/C	N/C	N/C
Customized Community Support	SDCB	N/C*	N/C	N/C	N/C
Consumable medical supplies	X	Limits	Limits	Limits	Limits
Day Treatment Services	X	N/C*	X	N/C	N/C
Delivery and inpatient maternity services	X	X	X	X	X
Dental anesthesia for injury	X	X	X	X	X
Dental Services	X	X	Limits	Limits	Limits
Diagonstic Imaging and Therapeutic Radiology Services	X	X	X	X	X
Dialysis Services	X	X	X	X	X
Disease Management	X	X	X	X	X
Durable Medical Equipment and Supplies	X	Limits	X	X	X
Emergency Response	ABCB/SDCB	N/C*	N/C	N/C	N/C
Emergency Services (including emergency room visits and psychiatric ER)	X	X	X	X	X
Employment Supports	ABCB/SDCB	N/C*	N/C	N/C	N/C
Environmental Modifications	ABCB/SDCB	N/C*	N/C	N/C	N/C
Experimental or Investigational Procedures, Technology or Non-Drug Therapies	X	N/C*	Limits	Limits	Limits
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	X	Limits	X	N/C	N/C
EPSDT Personal Care Services	X	N/C*	N/C	N/C	N/C

MHNM Benefit Coverage for Centennial Care/Health Insurance MarketPlace/Options Plus/Medicare Options					
Benefit Name	**Centennial Care**	**CC ABP**	**HIM**	**Options Plus (SNP)**	**Options**
Federal Poverty Levels					
EPSDT Private Duty Nursing	X	N/C*	N/C	N/C	N/C
EPSDT Rehabilitation Services	X	X	N/C	N/C	N/C
Family Planning	X	X	X	N/C	N/C
Family Support (Behavioral Health)	X	N/C*	N/C	N/C	N/C
Federally Qualified Heatlh Center Services	X	X	X	X	X
Genetic Evaluation and Testing	N/C*	Limits	Limits	N/C	N/C
Habilitative Services	N/C*	Limits	X	X	X
Hearing Aids and Related Evaluations	X	N/C	N/C	N/C	N/C
Home Health Aide	ABCB/SDCB	N/C*	Limits	X	X
Home Health Services	X	Limits	Limits	X	X
Home Infusion Therapy	N/C*	X	N/C	X	X
Homemaker (SDCB Personal Care)	SDCB/SDCB	N/C*	N/C	N/C	N/C
Hospice Services	X	Limits	X	X	X
Hospital Inpatient (Including Detoxification services)	X	X	X	X	X
Hospital Outpatient	X	X	X	X	X
Immunizations	X	X	X	X	X
Inpatient Hospitalization medical/surgical care	X	X	X	X	X
Inpatient Hospitalizations in Freestanding Psychiatric Hospitals	X	N/C*	X	X	X
Inpatient Hospitalization in a psych unit of general hosp		X	X	X	X
Intensive Outpatient Program Services	X	X	X	Limits	Limits
IV Outpatient Services	X	X	N/C	N/C	N/C
Laboratory Services	X	X	X	X	X
Medication Assisted Treatment for Opioid Dependance	X	N/C*	X	N/C	N/C
Methadone	X	Limits	X	N/C	N/C
Midwife Services	X	X	X	N/C	N/C
Multi-Systemic Therapy Services	X	X	N/C	X	X
Non-Accredited Residential Treatment Centers and Group Homes	X	N/C*	N/C	N/C	N/C
Non-emergency transportation	X	X	Limits	Limits	N/C
Nursing Facility Services	X	N/C	X	Limits	Limits

MHNM Benefit Coverage for Centennial Care/Health Insurance MarketPlace/Options Plus/Medicare Options					
Benefit Name	**Centennial Care**	**CC ABP**	**HIM**	**Options Plus (SNP)**	**Options**
Federal Poverty Levels					
Nutritional Counseling	SDCB	X	X	Limits	Limits
Nutritional Services	X	X	X	Limits	Limits
Occupational Services	X	Limits	X	X	X
Oupatient Hosptial based Psychiatric Services and Partial Hospitalizations	X	N/C*	X	X	X
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	X	N/C*	X	X	X
Oral anti-cancer medication	N/C*	X	X	Limits	Limits
Oral Surgery	?	Limits	Limits	Limits	Limits
Organ and tissue transplants	X	Limits	Limits	Limits	Limits
Orthotics	X	Limits	X	X	X
Outpatient Health Care Professional Services	X	X	X	X	X
Outpatient Surgery	X	X	X	X	X
Personal Care Services	ABCB	N/C	N/C	N/C	N/C
Pharmacy Services	X	X	X	X	X
Physical Health Services	X	X	X	X	X
Physical Therapy	X	Limits	X	X	X
Physician Visits	X	X	X	X	X
Podiatry Services	X	X	Limits	Limits	Limits
Pre-and post-natal care	X	X	X	X	X
Pregnancy Termination Procedures	X	X	X	Limits	Limits
Preventive Services	X	X	X	X	X
Private Duty Nursing for Adults	ABCB/SDCB	N/C*	N/C	N/C	N/C
Prosthetics and Orthotics	X	Limits	Limits	X	X
Prosthetics and reconstructive services	N/C*	Limits	Limits	Limits	Limits
Prosthodontics (fixed)	N/C*	Limits	N/C	N/C	N/C
Prosthodontics (removable)	N/C*	Limits	N/C	Limits	Limits
Psychosocial Rehailition Services	X	N/C*	N/C	N/C	N/C
Pulmonary Rehabilitation	X	Limits	X	X	X

MHNM Benefit Coverage for Centennial Care/Health Insurance MarketPlace/Options Plus/Medicare Options					
Benefit Name	**Centennial Care**	**CC ABP**	**HIM**	**Options Plus (SNP)**	**Options**
Federal Poverty Levels					
Radiation Therapy	X	X	X	X	X
Radiology Facilities	X	X	X	X	X
Recovery Services (Behavioral Health)	X	N/C*	N/C	N/C	N/C
Rehabilitation Option Services	X	N/C*	N/C	N/C	N/C
Rehabilitation Services Providers	X	X	X	X	X
Related Goods	SDCB	N/C*	N/C	N/C	N/C
Reproductive Health Services	X	X	X	X	X
Respiratory Therapy (Inpatient Only)	N/C*	X	X	X	X
Respite (Behavioral Health)	X	N/C*	N/C	N/C	N/C
Respite	ABCB/SDCB	N/C*	Limits	Limits	Limits
Restorative dental services	X	X	N/C	Limits	Limits
Routine Foot Care	N/C*	Limits	N/C	Limits	Limits
Rural Health Clinics Services	X	N/C*	X	X	X
School-Based Services	X	N/C*	N/C	N/C	N/C
Screening Mammography	X	X	X	X	X
Skilled Maintenance Therapy Services	ABCB/SDCB	N/C*	N/C	N/C	N/C
Skilled Nursing	N/C*	Limits	Limits	Limits	Limits
Sleep Studies	X	NC	N/C	N/C	N/C
Smoking Cessation Services	X	X	X	X	X
Specialist visits	X	X	X	X	X
Specialized Therapies	SDCB	N/C*	N/C	N/C	N/C
Speech and Language Therapy	X	Limits	X	X	X
Sterlization	N/C*	X	X	N/C	N/C
Suboxone	X	Limits	X	X	X
Swing Bed Hosptial Services	X	N/C*	X	X	X
Telehealth Services	X	N/C*	N/C	Limits	Limits
Telemedical Services	N/C*	X	N/C	N/C	N/C
Tot-to-Teen Health Checks	X	N/C*	X	N/C	N/C
Transportation Services (medical)	X	X	X	X	X

MHNM Benefit Coverage for Centennial Care/Health Insurance MarketPlace/Options Plus/Medicare Options					
Benefit Name	**Centennial Care**	**CC ABP**	**HIM**	**Options Plus (SNP)**	**Options**
Federal Poverty Levels					
Transportation Services (non-medical)	SDCB	X	Limits	Limits	Limits
Treatment for alcoholism and drug dependency	X	Limits	X	X	X
Treatment Foster Care	X	N/C*	N/C	N/C	N/C
Treatment Foster Care II	X	N/C*	N/C	N/C	N/C
Urgent care centers/facilities	X	X	X	X	X
Vision Services	X	Limits	Limits	Limits	Limits

MOLINA® HEALTHCARE

ABP Limitations	
Benefit Name	**Limitations**
Autism Spectrum Disorder	Part of EPSDT for 19 & 20 year-olds; and as state mandate for dx and treatemetn for individuals 19-23 who are enrolle din high school up to $36,000/year and $200,000/lifetime.
Bariatric Surgery	One procedure per lifetime
Cardiac Rehab	36 visits/year
Consumable medical supplies	Limitations on covered supplies
Diagnostic dental services	one oral exam/year; emergency exams
Dental radiology services	one complete series or set of panoramic films/60 months; bitewing x-rays every 12 months
Preventive dental services	one prophylaxis service every 12 months; flouride treatment every 12 months
Restorative dental services	amalgam restorations on permanent and deciduous teeth; resin restorations for anterior and posterior teeth; one prefab stainless steel or resin crown per permanent or deciduous tooth; one recementation of a crown or inlay
Durable Medical Equipment and Supplies	limitations on covered equipment
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	for 19 & 20 year-olds
Genetic Evaluation and Testing	Triple serum test and counseling only
Habilitative Services	at parity with rehabilitative services - limited to no more than two consecutive months per condition; exceptions based on medical necessity
Home Health Services	100 4-hour visits
Hospice Services	$10,000 lifetime maximum
Methadone	limitations on duration, e.g., 30 days
Occupational Services	Limited to no more than two consecutive months per condition; exceptions based on medical necessity
Oral Surgery	simple and surgical extractions; incision and drainage of an abscess
Organ and tissue transplants	subject to lifetime transplant limits
Orthotics	with RX; does not cover shoes except with dx of diabetes
Physical Therapy	Limited to no more than two consecutive months per condition; exceptions based on medical necessity
Prosthetics and Orthotics	Limit on Orthotics
Prosthetics and reconstructive services	with limitations
Prosthodontics (fixed)	one recementation of a fixed bridge only; fixed dentures not covered
Prosthodontics (removable)	Dentures every 5 years; two denture adjustments every 12 months; denture repairs

ABP Limitations	
Benefit Name	**Limitations**
Pulmonary Rehabilitation	36 visits/year
Routine Foot Care	with qualifying dx
Skilled nursing	60 days/year
Speech and Language Therapy	Limited to no more than two consecutive months per condition; exceptions based on medical necessity
Suboxone	limitations on duration, e.g., 30 days
Treatment for alcoholism and drug dependency	Excluding RTCs
Vision Services	Vision hardware not covered except following removal of catarcts as part of EPSDT for 19 & 20 year olds
Vision Screening	As part of wellness exam only

CC VAS							
Value Added Service	Description	Definition	Limitations	Provider	Geographic Availability	Effective Date	Rev Code
Dental Varnish	Reimbursing PCPs to apply topical fluoride varnish for Members with moderate to high dental caries risk.	Prescription strength fluoride product delivered to the dentition by a child's PCP. Please note that this is Centennial Care covered service for children 3 years and older.	Benefit available to children 0 - 3 years old.	PCPs	All regions	1/1/14	D1206
Electroconvulsive Therapy (ECT)	Short-Term ECT & Maintenance ECT for typically adults but will evaluate for pediatric population on a case by case basis.	For use as a treatment for severe depression that has not responded to other treatment. Short-Term ECT is given for a limited number of times per week for a limited number of weeks. Maintenance ECT is provided as required; maintenance ECT is provided less frequently than Short-Term ECT, i.e. once per week/two weeks/month.	Based on medical necessity and requires approval by Behavioral Health Medical Director or Chief Medical Officer.	UNM Hospital	Services are only available at the University of New Mexico Hospital (UNMH.) Members throughout the state can access these services at UNMH.	1/1/14	90870
Infant Mental Health	Relationship-focused interventions to the parents, foster parents, or other primary caregivers with infants and toddlers.	Infant Mental Health Services (IMH) targets infants (0-3) in distress or with clear symptoms indicating a mental health disorder. IMH address problems with attachment and relationships in families, focus on the parent-child relationship, and are designed to improve infant and family functioning in order to reduce risk for more severe behavioral, social, emotional, and relationship disturbances as infants get older.	Benefit available to parents/foster parents/caregivers of Members 0 - 3 years old. Total of $200,000 maximum per calendar year for all IMH services rendered.	"PB&J Family Services amd Family Services	PB&J Family Services: Bernalillo, Sandoval, and Valencia counties Las Cumbres Family Services: Los Alamos, Rio Arriba, Santa Fe, and Taos Counties	1/1/2014	T1027 HU
Cell Phone Programs	Provides high-risk members who meet specific criteria with pre-programmed cell phones.	High Risk members (Level 2, Level 3, High Risk Pregnancy or other situations on a case by case basis). Members who do not have reliable landline or cellphone service available. The phone is provided for short duration to enable the member to contact their providers and Molina Care Coordination team.	There is a limit of 250 minutes per month. Benefit excludes Self-Directed Community Benefit members.	Vendor	All regions	1/1/2014	N/A
Non-Maternity Related Services to Women Enrolled in Category of Eligibility (COE) for Maternity-Related Services Only.	All Medical, BH, Dental, Vision and Transportation for all pregnant women enrolled in maternity-only COE.	Women in this COE are provided Medicaid benefits for pregnancy-related services. Molina is providing the full Medicaid benefit to these women, with the exception of Long Term Care and Community Benefits.	Category of Eligibility Description: Pregnancy-Related Services.	All	All regions	1/1/14	Varies
Post Hospitalization Homeless Lodging	Provides services to promote a safe discharge from an acute hospitalization.	Allows homeless members to stay in hotels for up to two weeks during the transition from hospital to home. Required care such as infusion therapy or skilled nursing services would be provided in this setting.	Member must be homeless, requiring additional services. Limited to two weeks.	Lodging providers	Statewide	1/1/14	ITM
School Sports Physicals	Physical examinations and completion of paperwork so that members can participate in sporting activities.	This is a medical examination for administrative purposes rather than medical diagnosis or treatment.	Benefit available to children 12 - 18 years old. One physical per calendar year.	SBHC	All regions	1/1/14	99381-99385& V70.3

CC VAS							
Value Added Service	Description	Definition	Limitations	Provider	Geographic Availability	Effective Date	Rev Code
Traditional Healing Benefit	Provides spiritual services with cultural sensitivity for traditional healing rituals.	The Traditional Medicine Benefit helps members using traditional healing services. Members may use the healer of their choice for the healing ceremony of their choice.	$200.00 per Member per calendar year for in-home services. $100.00 per member per calendar year for services done in a clinic or hospital setting. Benefit excludes Self-Directed Community Benefit members.	Determined by Member	All regions	1/1/14	Invoice
Transitional Living Services (Adults & Adolescents/Young Adults)	Supervised voluntary residential treatment, habilitative, and rehabilitative services in a structured, community-oriented environment	An interim residential program offering 24-hour supervised voluntary residential treatment, habilitative, and rehabilitative services in a structured, community-oriented environment. Also called "transitional living", the services are designed for individuals who have the potential and motivation to ameliorate some skills deficits through a moderately structured rehabilitative housing program.	Benefit available to: Members age 21 years and older: 180 day maximum per member per calendar year. $400,000 total program costs. Members age 17 to 21: 180 day maximum per member per calendar year. $700,000 total program costs. Average Length of Stay is three (3) to five (5) months per Member. No other limitations at this time.	Varies by region		1/1/2014	H0019
Weight Watchers	Provides services to promote healthy eating and activities.	At Weight Watchers, we recognize that food is only one part of the weight-loss equation. Activity, healthy habits, support and smart food choices; these are the keys that can lead to real, lasting success. (From Weightwatchers.com)	Members age 18 and older with BMIs >30 OR 85th percentile for age/weight. 10 passes + 5 additional passes when Member has attended 10 Weight Watcher meetings.	Weight Watchers	Weight Watchers programs are available throughout New Mexico EXCEPT in the following counties: Catron, DeBaca, Guadalupe, Harding, Mor	1/1/2014	Invoice

MOLINA® HEALTHCARE

NEW MEXICO MEDICAID PROGRAM COPAYMENTS (updated 9-25-2013) CHIP RECIPIENTS Children's Health Insurance Plan Categories of Eligibility 071, 0420, and 0421 Copayment only applies when the federal match code is 1			
EXEMPTIONS for CHIP Recipients:	**PHARMACY COPAYMENT:**	**OTHER COPAYMENTS:**	**COPAYMENTS FOR UNNECESSARY SERVICES:**
1. Native Americans (race code 3)			
2. Family planning services, procedures drugs, supplies, and devices	$ 2 per drug item	$ 5 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session Does not apply to emergency room professional charges because the ER facility copayment applies. Only one copayment is applied per visit or session.	$ 50 for non emergent use of ER
3. Medicare Cross Over claims including claims from Medicare Advantage Plans	Does not apply if the copayment for unnecessary drug utilization is assessed.		
4. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc. – see detailed notes below)		NOTE: When the "visit" takes place in an outpatient hospital or urgent care center, which typically involves both a facility component and a professional (physician) component, the copayment is applied to the professional charge, not to the facility charge.	$ 5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.
5. Prenatal & postpartum care and deliveries, and prenatal drug items			
6. Provider preventable conditions			
7. Psychotropic drug items (only the regular pharmacy copayment applies)		When the copayment is applied to any inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.	
8. When the maximum family limit has been exceeded. See detailed notes below.			See detailed notes at end of document
9. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code		$ 15 emergency room - Does not apply if the copayment for unnecessary use of the ER is assessed.	
10. Federal match 3 for COE's 071 and COE's 400 thru 421 are exempt because they are presumptively eligible children			

Except for Native Americans, the copay- ments for unnecessary services as described in the far right column may be applied without regard to the above exemptions.		$ 25 inpatient admission – Is not applied when the hospital is receiving the recipient as a transfer from another hospital	
WDI RECIPIENTS Working Disabled Individuals			
Category of eligibility: 074			
EXEMPTIONS for WDI Recipients:	**PHARMACY COPAYMENT:**	**OTHER COPAYMENTS:**	**COPAYMENTS FOR UNNECESSARY SERVICES:**
1. Native Americans (race code 3)			
2. Family planning services, procedures drugs, supplies, and devices	$ 5 per drug item		$ 28 for non emergent use of ER
3. Medicare Cross Over claims including claims from Medicare Advantage Plans		$ 7 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session Does not apply to emergency room professional charges	
4. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams etc. – see detailed notes below)	Does not apply if the copayment for unnecessary drug utilization is assessed.	because the ER facility copayment applies. Only one copayment is applied per visit or session.	
5. Prenatal & postpartum care and deliveries, and prenatal drug items		NOTE: Does apply to outpatient hospital clinic visits and urgent care visits, but is applied to the professional service, not the facility charge.	
6. Provider preventable conditions			$ 8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less
7. Psychotropic drug items (only the regular pharmacy copayment applies)		NOTE:	effective or have greater adverse reactions.
8. When the maximum family limit has been exceeded. See detail below.		When the “visit” takes place in an outpatient hospital or urgent care center, which typically involves both a facility component and a professional (physician) component, the copayment is applied to the professional charge, not to the facility charge.	
9. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code		When the copayment is applied to any inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.	
			See detailed notes at end of document

		$ 20 emergency room - Does not apply if the copayment for unnecessary use of the ER is assessed.	
Except for Native Americans, the copayments for unnecessary services as described in the far right column may be applied without regard to the above exemptions.		$ 30 inpatient admission - Is not applied when the hospital is receiving the recipient as a transfer from another hospital	

OTHER MEDICAID RECIPIENTS except CHIP, WDI, and Alternative Benefit Plans, which are addressed separately

Note that if the FPL is not available on January 1, 2014, use the lower copayment until the FPL level is available.

EXEMPTIONS:	PHARMACY COPAYMENT:	OTHER COPAYMENTS:	COPAYMENTS FOR UNNECESSARY SERVICES:
The following exemptions apply even when the copayments are for unnecessary services (non emergent use of the ER, and unnecessary use of a brand name drug) as described in the far right column:			Varies by FPL
	Not applicable	Not applicable	
1. Native Americans (race code 3)			$ 8 150% FPL or below
2. Medicare Cross Over claims including claims from Medicare Advantage Plans			$50 >150% FPL
3. The following categories of eligibility:			
014 foster care			
017 adoption			
037 adoption			$ 3 For a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less
046 foster care			effective or have greater
047 adoption			adverse reactions.

066 foster care			
081 institutional care			
083 institutional care			
084 institutional care			See detailed notes at end of document
086 foster care			

ABP - ALTERNATIVE BENEFIT PACKAGE

Note that if the FPL is not available on January 1, 2014, use the lower copayments until the FPL level is available.

Category of Eligibility 100

EXEMPTIONS for ABP	PHARMACY COPAYMENT:	OTHER COPAYMENTS: VARIES by FPL	COPAYMENTS FOR UNNECESSARY SERVICES:
1. Native Americans (race code 3)			
2. Emergency services (see notes at right)		For FPL up thru 100%:	
	$4 per drug item		$ 8 For non emergent use of ER
3. Family planning services, drugs, procedures, supplies, and devices		$4 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session.	
4. Hospice patients	Does not apply if the copayment for unnecessary drug utilization is assessed.	Does not apply to ER facility or ER professional charges.	
5. Medicare Cross Over claims including claims from Medicare Advantage Plans		NOTE: Does apply to outpatient hospital clinic visits and urgent care visits, but is applied to the professional service, not the facility charge.	
6. Pregnant women - all services unless MAD gets approval from CMS to exempt some services as not pregnancy related - so currently is it indeed all services for pregnant women.			
7. Prenatal & postpartum care and deliveries, and prenatal drug items		$ 10 inpatient admission - Is not applied when the hospital is receiving the recipient as a transfer from another hospital	$8 For a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.
8. Mental health (behavioral health) and substance abuse services			
9. Psychotropic drug items (only the regular pharmacy copayment applies)		For FPL 101-138%:	
10. All Preventive Services		$8 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session.	

11. Provider preventable conditions		Does not apply to ER facility or ER professional charges.	See detailed notes at end of document for applying these copayments
12. If the recipient's "disability type code" on the eligibility file is ME or PH			
13. When the maximum family limit has been exceeded. See detail below.		NOTE: For both copayments above, when the "visit" takes place in an outpatient hospital or urgent care center, which typically involves both a facility component and a professional (physician) component, the copayment is applied to the professional charge, not to the facility charge. When the copayment is applied to any inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.	
Except for Native Americans, the copayments for unnecessary services as described in the far right column may be applied without regard to the above exemptions.		$ 25 inpatient admission - Is not applied when the hospital is receiving the recipient as a transfer from another hospital Continued on next page -Emergency Services Exemption for Above ABP Copayments The ABP copayments do not apply when treatment is for an "exempt emergency service" as described in the Social Security Act and CFR. These provisions clearly exempt all medically necessary emergency room services from copays. However, there may be additional situations that qualify as emergency services. For additional information on this provision, see detailed notes at the end of this document.	

Note 1: Alternative Benchmark Plans: Notes on the Exemption from Copayments for Emergency Services

Exempt emergency services (federal definitions):

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

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

"Emergency services means covered inpatient and outpatient services that are as follows: (1) Furnished by a provider that is qualified to furnish these services under this title. (2) Needed to evaluate or stabilize an emergency medical condition.
Provider Responsibilities:
• Perhaps using MCO criteria, when the provider knows the service qualifies for the emergency exemption, the provider reports it to the MCO.
MCO Responsibilities:
• Not apply the ABP copayment to services in emergency rooms. Unless, the non-emergent use of the ER copayment is assessed, an emergency room service is presumed to be an emergency. Very likely, an inpatient hospital stay when the admission is through an emergency department, the inpatient hospital stay qualifies as an emergency.
The MCO may develop their own rules and process consistent with the federal requirements. MAD can provide direction as neces sary.
To recognize when other providers report the service as exempt from the copayment because it is an emergency. In which case the MCO does not deduct the ABP copayment from the amount paid to the provider.

MOLINA® HEALTHCARE

Marketplace Limitations	
Benefit Name	**Limitations**
Autism Spectrum Disorder	To be covered under this EOC, treatment for Autism Spectrum Disorder must be: 1) Medically Necessary; 2) prescribed by a physician who is a Participating Provider; and 3) provided under the Participating Provider's treatment plan. This plan includes: • Diagnosis; • Proposed treatment by types; • Frequency and duration of the treatment; • Anticipated outcomes stated as goals; • Frequency with which the treatment plan will be updated; • Signature of the treating physician. Benefits for the diagnosis of Autism Spectrum Disorder and for Covered Services under an approved treatment plan for Autism Spectrum Disorder are limited to 25 visits per calendar year for each affected Dependent child. Treatment must be received from appropriate Participating Provider health care professionals. Outpatient Office Visit Cost Sharing will apply. Coverage for Autism Spectrum Disorder shall not be denied on the basis that the services are habilitative or rehabilitative in nature. (This means that the services are treatment programs that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.) We do not cover treatment or services for Autism Spectrum Disorder when they are received under the Federal Individuals with Disabilities Education Improvement Act of 2004 (IDEA). We also do not cover treatment or services under specialized educational programs (for children ages 3 to 23) that are the responsibility of state and local school boards.
Bariatric Surgery	We cover hospital inpatient care related to bariatric surgical procedures. This includes room and board, imaging, laboratory, special procedures, and Participating Provider physician services. Included services are those performed to treat morbid obesity. Treatment means changing the gastrointestinal tract to reduce nutrient intake and absorption. all of the following requirements must be met to receive these services: • You complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes. These changes are necessary for long term bariatric surgery success. • A Participating Provider physician who is a specialist in bariatric care determines that the surgery is Medically Necessary.
Consumable medical supplies	Limitations on covered supplies
Dental Services	Limited to dental services for radiation treatment, dental anesthesia, cleft palate, dental injury and TMJ. Please consult the EOC for specifics for each type of service.

Experimental or Investigational Procedures, Technology or Non-Drug Therapies	Care must not be Experimental or Investigational. However, members may ask to be part of Experimental or Investigational care. Molina also may cover routine medical costs for Members in Approved Clinical Trials. Please consult the EOC for additional details.
Genetic Evaluation and Testing	Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high risk pregnancy
Home Health Aid	Up to two hours per visit for visits by a nurse, medical social worker, physician, occupational, or speech therapist and up to four hours per visit by a home health aide
Home Health Services	Up to two hours per visit for visits by a nurse, medical social worker, physician, occupational, or speech therapist and up to four hours per visit by a home health aide Up to three visits per day (counting all home health visits) Up to 100 visits per calendar year (counting all home health visits). Please consult the EOC for additional details.
Non-Emergency Transportation	Combined limit of 4 round trips per month. Applies to the Silver plans only.
Oral Surgery	Limited to cleft palate, trauma and TMJ.
Organ and tissue transplants	Limited to participating facilities.
Orthotics	Most orthotic devices are not covered. Please consult the EOC for specific details.
Podiatry	Routine foot care is covered for diabetics only.
Prosthetics and Orthotics	Most prosthetic and orthotic devices are not covered. Please consult the EOC for specific details.
Prosthetics and reconstructive services	Please consult the EOC for full details.
Respite	Respite care for up to seven days per occurrence. Only covered in conjunction with Hospice services.
Skilled nursing	limited to 60 days per calendar year
Non-Medical Transportation	Combined limit of 4 round trips per month. Applies to the Silver plans only.
Routine Foot Care	with qualifying dx
Vision	Eye exams and preventative vision screenings for adults. For a full explanation of the Pediatic Vision benefits, please consult the Pediatric Vision rider.

MOLINA® HEALTHCARE

Marketplace VAS							
Value Added Service	Description	Definition	Limitations	Provider	Geographic Availability	Effective Date	Rev Code
Non-emergency non-medical transportation	Non-emergency non-medical transportation is available for individuals who are recovering from serious injury or medical procedures which prevent the individual from driving to a medical appointment. Copayments range from $5 to $10 depending on the Silver plan level. Note: this benefit is not available to Bronze or Gold plan members.	Non-emergency non-medical transportation for members to medical serices can be supplied by a passenger car, taxi cab, or other forms of public/private transportation.	Limited to four (4) round trips per month. Transportation must be scheduled at least two (2) or three (3) working days in advance.	No specific vendor. The member may choose from the sources listed in the Definitions column.	Statewide.	1/1/2014.	N/A
Chiropractic	Chiropractic manipulation and diagnostic services.	Chiropractic diagnostic and treatment services are covered when furnished by a licensed participating provider. The treatment must be appropriate for the member's condition.	Limited to twenty (20) visits per calendar year.	Please consult the Marketplace provider directory for eligible providers.	Statewide.	1/1/2014.	TBD
Acupuncture	Treatment for the relief of chronic pain.	Acupuncture diagnostic and treatment services are covered when furnished by a licensed participating provider. The treatment must be appropriate for the member's condition.	Limisted to twenty (20) visits per calendar year.	Please consult the Marketplace provider directory for eligible providers.	Statewide.	1/1/2014	TBD
Bariatric Surgery	Surgical change to the gastrointestional tract to reduce nutrient intake and obsorption, in an effort to assist in the treatment of morbid obesity.	Coverage for bariatric surgery includes hospital room and board, imaging, laboratory, special procedures and participating provider physician services.	To be covered for this service, a member must complete the medical group-approved pre-surgical educational preparatory program regarding lifestyle changes. These changes are necessary for long-term bariatric surgery success.	Please consult the Marketplace provider directory for eligible providers.	Statewide.	1/1/2014	TBD

Smoking Cessation Program	Professional services to assist interested members to quit smoking	This program offers smoking cessation services to all smokers interested in quitting. Specialized services are available for teems, pregnant smokers and tobacco chewers. The program is done over the telephone. In addition, educational materials will be mailed to interested members.	None	?	Statewide.	1/1/2014	N/A
Weight Control Program	A professional program to assist members to achieve and maintain appropriate weight.	The Weight Control program is provided for members age 17 and older. Through this program, members will learn about healthy eating and exercise. To participate, members must understand and agree to the program participation criteria.	Must be age 17 or over and agree to the program participation criteria.	?	Statewide.	1/1/2014	N/A
Health Education Materials	Easy to read educational materials.	These materials cover such topics as nutrition, stress management, child safety, asthma and diabetes.	None	N/A	Statewide.	1/1/2014	N/A

MOLINA® HEALTHCARE

Options & Options Plus Limits	
Benefit Name	**Limitations**
Cancer Clinical Trials	Only trials approved by Medicare or Molina.
Bariatric Surgery	We cover hospital inpatient care related to bariatric surgical procedures. This includes room and board, imaging, laboratory, special procedures, and Participating Provider physician services. Included services are those performed to treat morbid obesity. Treatment means changing the gastrointestinal tract to reduce nutrient intake and absorption. all of the following requirements must be met to receive these services: • You complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes. These changes are necessary for long term bariatric surgery success. • A Participating Provider physician who is a specialist in bariatric care determines that the surgery is Medically Necessary.
Consumable medical supplies	Limitations on covered supplies
Dental Services	Molina offers enhanced dental services. Please refer to the EOC for a list of covered dental (ADA) procedure codes.
Experimental or Investigational Procedures, Technology or Non-Drug Therapies	Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
Intensive Outpatient Program Services	Cardiac rehabilitation and weight loss only.
Non-Emergency Transportation	Available for Options Plus only. Please consult the EOC for full details.
Nursing Facility	100 days for each benefit period
Nutritional Counseling	For approved diagnoses only (diabetes and kidney disease).
Nutritional Services	For approved diagnoses only (diabetes and kidney disease).
Oral Anti-Cancer Medication	Limited to certain drugs. Please consult the formulary.
Oral Surgery	Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)
Organ and Tissue Transplants	Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.

Podiatry	Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) and rRoutine foot care for members with certain medical conditions affecting the lower limbs
Pregnancy Termination Procedures	Elective Abortions are not covered except under those circumstances allowed by Medicare regulations
Prosthetics and reconstructive services	Covered due to injury or illness or for reconstruction after mastectomy.
Prostodontics (removable)	Please consult the EOC for a list of eligible dental (ADA) procedure codes.
Respite	Only covered in conjunction with Hospice services.
Restorative Dental Services	Please consult the EOC for a list of eligible dental (ADA) procedure codes.
Routine Foot Care	with qualifying dx
Skilled nursing	Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
Telehealth Services	Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare
Non-Medical Transportation	Available for Options Plus only. Please consult the EOC for full details.
Vision	Please consult the EOC for a complete explanation of covered vision services.