Molina Healthcare of Illinois
Member Services: (855) 766-5462 or TTY 711
www.MolinaHealthcare.com

Benefits at a Glance

Our goal is to provide you with the best care possible. Molina Healthcare covers medically necessary Medicaid-covered services. The services covered by Molina Healthcare are covered at no cost to you. This chart is a complete list of services Molina Healthcare covers. It also helps you know services that require PA. If you have any questions, call Member Services.

Service	Coverage & Benefit Limitations	Prior Authorization
Advanced Practice Nurse services	Covered benefit	
Ambulatory surgery	Covered benefit	Some ambulatory surgeries require PA.
Chiropractic services	Limited to members 19 and 20 years of age for the treatment of the spine by manual manipulation.	Requires PA.
Dental services	Dental services, including oral surgery, X-rays, sealants, fillings, crowns (caps), root canals, dentures and extractions (pulling), for members 19 and 20 years of age. Dental exams (1 per year for members 19 and 20 years of age). One cleaning every six months for members 19 and 20 years of age. One cleaning per calendar year for members 21 years of age and older. Practice visits for individuals with developmental disabilities and serious illness. Adult dental services are limited to emergencies.	
Emergency dental services	Covered benefit	
Diagnostic services (X-ray, lab)	Covered benefit	Selected diagnostic services (including CT scans, MRIs, MRAs, PET Scans, and SPECT) require PA.

Service	Coverage & Benefit Limitations	Prior Authorization
Durable Medical Equipment (DME)	Covered benefit	Some durable medical equipment items require PA.
Emergency services	Covered benefit	PA is not required.
EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services	Covered for members 19 and 20 years of age.	
Family planning services and supplies	Covered benefit	Some family planning services and supplies require PA.
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Covered benefit	
Hearing (audiology) services, including hearing aids	Covered benefit	Requires PA.
Home health services	Covered benefit	Requires PA.
Hospice care (care for terminally ill)	Covered benefit	
Inpatient hospital services	Covered benefit	Inpatient hospital services (except for emergency admissions) and elective admissions require PA. Notification to Molina Healthcare is required within 24 hours of admission or by the next business day for emergency admissions.
Long Term Services and Supports (Waiver Services)	Determination of need must be completed specifically for individuals eligible for specific waiver programs. Refer to the Waiver Program Handbook Supplement for coverage information.	
Medical supplies	Covered benefit	Some medical supplies require PA.
Mental health and substance abuse services	Covered benefit	PA is not required for services received at an in-network: • Community mental health center • Division of Mental Health (DMH) facility • Division of Alcoholism and Substance Abuse (DASA) facility, or • Illinois Department of Human Services (DHS) facility Services require PA after 20 visits per year if received at facilities other than a community mental health center or DMH, DASA or DHS facilities.

Service	Coverage & Benefit Limitations	Prior Authorization
Nursing facility services	Covered benefit Also covered for members ages 19 and 20 who are not in the Medically Fragile Technology Dependent (MFTD) Waiver, with the purpose of transitioning the member from a hospital to the home or other appropriate setting.	Short-term inpatient rehabilitative nursing facility stays require PA.
Obstetrical (maternity care: prenatal and postpartum including at-risk pregnancy services) and gynecological services.	Covered benefit Women may self-refer Practice visits for individuals with developmental disabilities and serious illness.	PA is not required.
Outpatient hospital services	Covered benefit	Some outpatient services require PA.
Physical and occupational therapy	Limited to 20 services per year	Outpatient services require PA after the initial evaluation and six visits. Services provided in the home require PA after the initial evaluation and three visits.
Podiatry (foot) services	All podiatry services are covered for members 19 and 20 years of age. For individuals 21 years of age and older with Diabetes, one visit is covered every 60 days.	
Post-stabilization services	Covered benefit	
Practice Visits	Covered benefit for enrollees with Special Needs	
Prescription drugs, including certain prescribed over-the-counter drugs	Covered benefit 30-day supply of prescription drugs mailed to your home	Selected drugs, including injectables and some over-the-counter drugs, require PA.
Preventive mammogram (breast) and cervical cancer (pap smear) exams.	Covered benefit	PA is not required.
Primary care provider (PCP) services	Covered benefit	PA is not required.
Renal dialysis (kidney disease)	Covered benefit	PA is not required.
Respiratory equipment and supplies	Covered benefit	
Specialist services	Covered benefit PCP referral required to see all specialists, except women's health care providers	Office visits to see a network specialist do not require PA. Some specialist services require PA.
Speech therapy services	Limited to 20 services per year	Requires PA.

Service	Coverage & Benefit Limitations	Prior Authorization
Transportation to covered services	Covered benefit	Requires PA.
Vision (optical and optometrist) services, including eyeglasses	One exam per year One pair of glasses in a two-year period No restrictions on replacement glasses for members 19 and 20 years of age Members 21 years of age and older are limited to replacement lenses when medically necessary	Requires PA.
Yearly well-adult exams	Covered benefit	PA is not required.