Molina Healthcare

Medicaid Managed Care Member Handbook

MolinaHealthcare.com

MOLINA® HEALTHCARE

Your Extended Family.

July 2020

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MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare of New York, Inc.

Molina Healthcare of New York, Inc. (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

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

If you need these services, contact Molina Member Services at 1-800-223-7242 or TTY: 711.

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

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (310) 507-6186.

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

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

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

If you need help, call 1-800-368-1019; TTY 800-537-7697.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-223-7242 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-223-7242 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-223-7242（TTY：711）。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-223-7242 (телетайп: 711).
French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-223-7242 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-223-7242 (TTY: 711) 번으로 전화해 주십시오.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-223-7242 (TTY: 711).
Yiddish	אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-223-7242 (TTY: 711).
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-223-7242 (TTY: 711)।
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-223-7242 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-223-7242 (رقم هاتف الصم والبكم: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-223-7242 (ATS: 711).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-223-7242 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-223-7242 (TTY: 711).
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-223-7242 (TTY: 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-223-7242 (TTY: 711).
Nepali	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-223-7242 (टिटिवाइ: 711) ।

Here's Where to Find Information You Want

Welcome

Part 1: First Things You Should Know

Part 2: Your Benefits and Plan Procedures

Welcome

Welcome to Molina Healthcare's Medicaid Managed Care Program

We are glad that you enrolled in Molina Healthcare. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at 1-800-223-7242 (TTY: 711).

HOW MANAGED CARE PLANS WORK

The Plan, Our Providers, and You

- You may have heard about the changes in health care. Many members get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through Molina Healthcare.
- Molina Healthcare has a contract with the State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our **provider network.** You will find a list in our provider directory. If you do not have a provider directory, call 1-800-223-7242 (TTY: 711) to get a copy or visit our website at www.molinahealthcare.com.
- When you join Molina Healthcare, one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.
- Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 15 for details.
- When you join Molina Healthcare PLUS one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). You may want to choose a PCP from your mental health or substance use clinic. If you need to have a test, see another specialist, or go into the hospital, your Primary Care Provider will arrange it.
- You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted;

Confidentiality

We respect your right to privacy. Molina Healthcare recognizes the trust needed between you, your family, your doctors and other care providers. Molina Healthcare will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be Molina Healthcare, your Primary Care Provider and other providers who give you care and you authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider or your Health Home Care Manager, if you have one. Molina Healthcare staff has been trained in keeping strict member confidentiality.

HOW TO USE THIS HANDBOOK

This handbook will help you, when you join a managed care plan. It will tell you how your new health care system will work and how you can get the most from Molina Healthcare. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know **right** away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this Handbook or call our Member Services unit. You can also call the managed care staff at your local Department of Social Services.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:
Monday through Friday: 8:00AM - 6:00PM
1-800-223-7242 (TTY:711)

If you need help at other times, call us at: 1-800-223-7242 (TTY:711)
Calls after hours will be returned within 1 business day

- You can call Member Services to get help **any time you have a question.** You may call us to choose or change your Primary Care Provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.
- If you are or become pregnant, your child will become part of Molina Healthcare on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your **new born baby** before he or she is born.
- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.
- **If you do not speak English,** we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:
- **If you or your child is getting care in your home now,** your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

Member Rewards Program

Molina Healthcare of New York, Inc. wants you to know that your health is important to us. That is why we reward members for taking steps to a healthy future by offering $25 Walmart gift card and/or a car seat for completing certain visits and exams.

Please see chart and additional information below on how to claim your rewards:

Members who complete the following screenings and exams can earn a $25 WALMART GIFT CARD:
Adults:
Adult Well Visits Ages 19 – 64
Breast Cancer Screening (Ages 40+)
Cervical Cancer Screening (Ages 21-64) *discuss testing with your provider*
Colorectal Cancer Screening (Ages 50-75)
Diabetes (BOTH tests combined: HbA1c and Eye Exam)
Postpartum (visit 7 to 84 days after birth)
Prenatal (1 visit within the first trimester)

Car Seat Program
Members who complete a total of 6 prenatal visits can earn a car seat.
Children:
Well Child Check Ages 3 – 6
Well Child Check Ages 12 - 17

Please note: Gift cards cannot be used to purchase alcohol or tobacco products and cannot be converted to cash.

How it Works

We make it simple!

1) Molina will mail qualified members a post card reminder to schedule their appointments.

2) Members and/or providers fill out both areas of the post card.

3) Drop the completed post card in the mail (free postage!)

4) Your reward should arrive within 3-6 weeks.

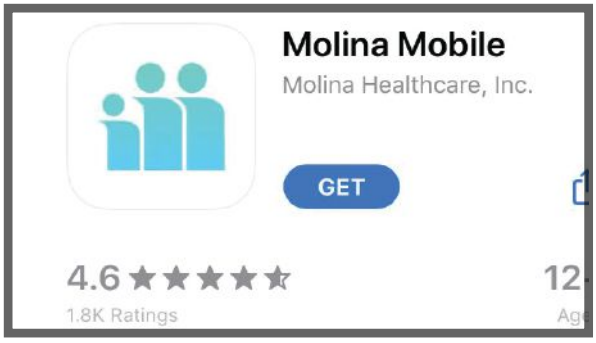
Note: If you don't receive a post card, please reach out to us directly at **MHNYQuality@MolinaHealthcare.com**

Molina Mobile App for Members

To use the Molina Mobile App, you must first download it from the Apple App Store (IPhone) or the Google Play Store (Android).

1. Open the App Store and search for “Molina Mobile”.
2. Download and install the Molina Mobile app on your device.
3. Open the Molina Mobile app. You are ready to go!

New Users will need to enter their Molina Member ID, date of birth, and state to register



Available in Spanish:
¡Disponible en Español!

Access all the same features as on MyMolina, plus:

- Face ID Recognition
- Favorite Doctor Option
- Improved bill pay for Marketplace Members
- Improved virtual ID cards with sharing and printing options
- Pharmacy Finder
- Symptom Checker
- Urgent Care Finder

Members can refer to the FAQ section in the app to see more features available.

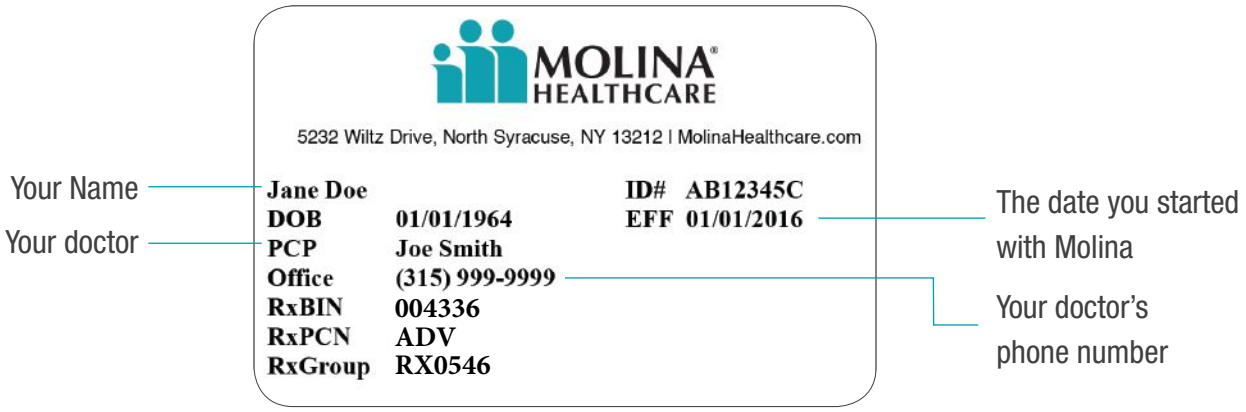
Questions?

Call Members Services at
(800) 223-7242 (TTY:711)

YOUR HEALTH PLAN ID CARD

After you enroll, we will send you a Welcome Letter. Your Molina Healthcare card should arrive within 14 days after your enrollment date. Your card has your PCP's name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your Molina Healthcare card, call us right away. Your ID card does not show that you have Medicaid or that Molina Healthcare is a special type of health plan.

- Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that Molina Healthcare does not cover.

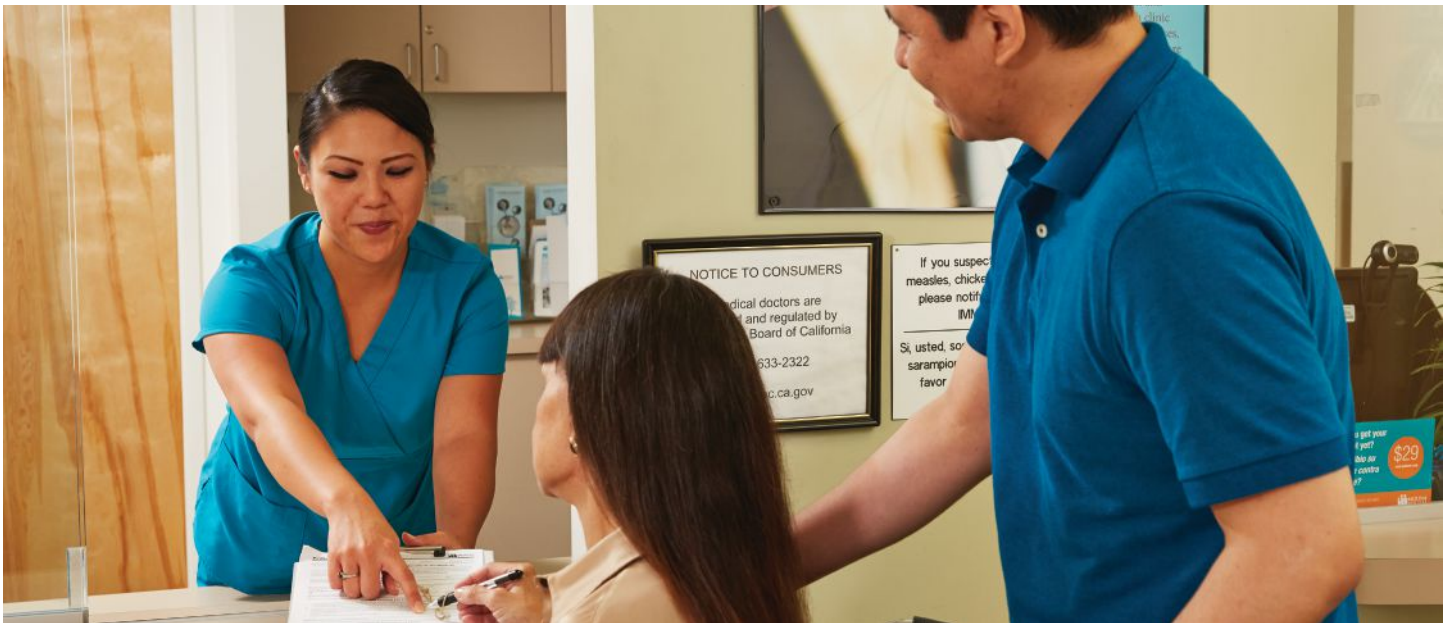


Part 1: First Things You Should Know

HOW TO CHOOSE YOUR PRIMARY CARE PROVIDER (PCP)

- You may have already picked your PCP to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for you and your family, you should do so right away**. If you do not choose a doctor within 30 days, we will choose one for you.
- Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP. Member Services (1-800-223-7242, TTY: 711) can check to see if you already have a PCP or help you choose a PCP.
- When you join Molina Healthcare PLUS one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). You may want to choose a PCP from your mental health or substance use clinic. If you need to have a test, see another specialist, or go into the hospital, your Primary Care Provider will arrange it.
- With this Handbook, you should have a provider directory. This is a list of all the doctors, clinics, hospitals, labs, and others who work with Molina Healthcare. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also get a list of providers on our website at www.molinahealthcare.com.

  You may want to find a doctor that:
  - you have seen before,
  - understands your health problems,
  - is taking new patients,
  - can serve you in your language, or
  - is easy to get to.
- Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if needed, and regular care during pregnancy.
- We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some members want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with, listed below. Just call Member Services at 1-800-223-7242 (TTY: 711) for help.



Syracuse Community Health Center
819 South Salina Street, Syracuse, NY 13202
Phone: 1-315-476-7921

Northern Oswego County Health Services
Pulaski Health Center
61 Delano Street, Pulaski, NY 13142
Phone: 1-315-298-6564

Family Health Network of Central New York, Inc.
Cortland Family Medical Center
4038 West Road, Cortland, NY 13045
Phone: 1-607-758-3008

Binghamton Psychiatric Center
425 Robinson Street
Binghamton, NY 13905
Phone: 1-607-724-1391

Family and Children's Society Inc.
28 North Main Street
Cortland, NY 13905
Phone: 1-607-753-0234

Our Lady of Lourdes Memorial Hospital
169 Riverside Drive
Binghamton, NY 13901
Phone: 1-607-584-5459

United Health Services Hospital Inc.
20 Mitchell Avenue
Binghamton, NY 13790
Phone: 1-607-762-3027

Cornerstone Family Healthcare
35 Felters Road
Binghamton, NY 13903
Phone: 1-607-201-1200

In almost all cases, your doctors will be Molina Healthcare providers. There are four instances when you can still **see another provider that you had before you joined Molina Healthcare.** In these cases, your provider must agree to work with Molina Healthcare. You can continue to see your doctor if:

- You are more than 3 months pregnant when you join Molina Healthcare and you are getting prenatal care. In that case, you can keep your provider until after your delivery through post-partum care.
- At the time you join Molina Healthcare, you have a life-threatening-disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join Molina Health care of New York, Inc; you are being treated treated for a Behavioral Health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this changes. Molina Healthcare of New York, Inc. will work with you and your provider to make sure you keep getting the care you need.
- At the time you join Molina Healthcare, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days.

Molina Healthcare must tell you about any changes to your home care before the changes take effect.

- If you have a long-lasting illness, like HIV/AIDS or other long-term health problems, you may be able to **choose a specialist** to act as your PCP. You and/or your PCP can request a specialist or specialty center be designated as your PCP. Your PCP can contact Molina Healthcare to make this request. If you want to make the request yourself, contact Member Services.
- If you need to, you can change your PCP in the first 30 days after your first appointment with your PCP. After that, you can change every six months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to whom your PCP has referred you.
- If your provider leaves Molina Healthcare, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days

after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-223-7242 (TTY: 711).

HEALTH HOME CARE MANAGEMENT

Molina Healthcare wants to meet all of your health needs. If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services.

A Health Home Care Manager can:

- work with your PCP and other providers to coordinate all of your health care;
- work with the people you trust, like family members or friends, to help you plan and get your care;
- help with appointments with your PCP and other providers; and
- help manage ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Member Services at 1-800-223-7242 (TTY: 711)

HOW TO GET REGULAR HEALTH CARE

- Regular health care means exams, regular check-ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need.
- Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.
- Your care must be **medically necessary.** The services you get must be needed:
  1. to prevent, or diagnose and correct what could cause more suffering, or
  2. to deal with a danger to your life, or
  3. to deal with a problem that could cause illness, or
  4. to deal with something that could limit your normal activities.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.
- As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.
- **If you need care before your first appointment,** call your PCP's office to explain your concern. He or she will give you an earlier appointment. You should still keep the first appointment to discuss your medical history and ask questions.
- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for an appointment:**
  - adult baseline and routine physicals: within 12 weeks
  - urgent care: within 24 hours
  - non-urgent sick visits: within 3 days
  - routine, preventive care: within 4 weeks

- first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
- first newborn visit: within 2 weeks of hospital discharge
- first family planning visit: within 2 weeks
- follow-up visit after mental health/substance use ER or inpatient visit: 5 days
- non-urgent mental health or substance use visit: 2 weeks

HOW TO GET SPECIALTY CARE

- If you need care that your PCP cannot give, he or she will help REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are Molina Healthcare providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask Molina Healthcare to approve *before* you can get them. Your PCP will be able to tell you what they are.
- If you are having trouble getting a referral you think you need, contact Member Services at 1-800-223-7242 (TTY: 711).
- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an out-of-network referral. Your PCP or plan provider must ask Molina Healthcare for approval before you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

Members may request care from a specialist or provider outside the network from their PCP. The member's PCP will submit the request to Molina Healthcare by faxing medical records and rationale for why the member requires care from a provider outside the network to Molina Healthcare at 1-866-879-4742. Once all necessary information is received to make the determination, Molina Healthcare will make the determination within 3 business days.

- Sometimes we may not approve an out-of-network referral because we have a provider in Molina Healthcare that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal** See page 35 to find out how.
- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from Molina Healthcare's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal** See page 35 to find out how.

- Your doctor must be a board certified or board eligible specialist who treats people who need the treatment you are asking for.
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time **(a standing referral).** If you have a standing referral, you will not need a new referral for each time you need care.

If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:

- your specialist to act as your PCP; or
- a referral to a specialty care center that deals with the treatment of your problem. You can also call Member Services for help in getting access to a specialty care center.

GET THESE SERVICES FROM OUR PLAN WITHOUT A REFERRAL

Women's Health Care

You do not need a referral from your PCP to see one of our providers if:

- you are pregnant;
- you need OB/GYN services;
- you need family planning services;
- you want to see a mid-wife;
- you need to have a breast or pelvic exam.

Family Planning

- You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, or an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.
- You *do not need a referral* from your PCP to get these services. In fact, you can choose where to get these services. You can *use your* Molina Healthcare *ID card* to see one of our family planning providers. Check the plan's Provider Directory or call Member Services for help in finding a provider.
- Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services 1-800-223-7242 (TTY: 711) for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV and STI Screening

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your regular health care.

- You can get an HIV or STI test any time you have an office or clinic visit.
- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Just make an appointment with any family planning provider). If you want an HIV or STI test, but *not as part of a family planning service,* your PCP can provide or arrange it for you.
- Or, if you'd rather not see one of our Molina Healthcare's providers, you can use your Medicaid card to see a family planning provider outside Molina Healthcare. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at 1-800-223-7242 (TTY: 711).
- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

Some tests are "rapid tests" and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

Eye Care

The covered benefits include the needed services of an ophthalmologist, optometrist and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12 month period. You just choose one of our participating providers.

New eye glasses, with Medicaid approved frames, are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral Health – (Mental Health and Substance Use)

We want to help you get the mental health and drug or alcohol abuse services that you may need. If at any time you think you need help with mental health or substance use, you can see behavioral health providers in our network to see what services you may need. This includes services like clinic and detox services. You do not need a referral from your PCP.

Harm Reduction Services

If you are in need of help related to substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. Molina Healthcare covers services that may help reduce substance use and other related harms. These services include:

- A plan of care developed by a person experienced in working with substance users.
- Individual supportive counseling that assists in achieving your goals.
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being.
- Counseling to help you with taking your prescribed medication and continuing treatment.
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you.

To learn more about these services, call Member Services at 1-800-223-7242 (TTY: 711)

Smoking Cessation

You can get medication, supplies and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services.

Maternal Depression Screening

If you are pregnant and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening for depression during pregnancy and for up to a year after your delivery.

Emergencies

You are always covered for emergencies.

An emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms.

An emergency would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away. Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing, convulsions, or loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting
- drug overdose

Examples of **non-emergencies** are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. Non-emergencies may also be family issues, a break up, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

If you have an emergency, here's what to do:

If you believe you have an **emergency,** call 911 or go to the emergency room. You do not need your plan's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

- **If you're not sure, call your PCP or Molina Healthcare.**
  Tell the person you speak with what is happening. Your PCP or member services representative will:
  - tell you what to do at home;
  - tell you to come to the PCP's office; or
  - tell you to go to the nearest emergency room.
- If you are **out of the area** when you have an emergency:
  - go to the nearest emergency room.

Remember

You do not need prior approval for emergency services. Use the emergency room **only** if you have an **Emergency.**

The Emergency Room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your PCP or Molina Healthcare at 1-800-223-7242 (TTY: 711).

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be a child with an ear ache who wakes up in the middle of the night and won't stop crying.
- This could be the flu or if you need stitches.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-223-7242 (TTY: 711). Tell the person who answers what is happening. They will tell you what to do.

Care Outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

WE WANT TO KEEP YOU HEALTHY

Besides the regular checkups and the shots you and your family need, here are some other ways to keep you in good health:

- Classes for you and your family
- Stop-smoking classes
- Pre-natal care and nutrition
- Grief / Loss support
- Breast feeding and baby care
- Stress management
- Weight control

- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Sexually Transmitted Infection (STI) Testing & Protecting Yourself from STIs
- Domestic Violence Services

Attached is a listing of services in your area for you to access. Call Member Services at 1-800-223-7242 (TTY: 711) to find out more and get a list of upcoming classes.

Health Promotion Programs:

St. Joseph's Hospital
7246 Janus Park Drive, Liverpool, NY 13088
1-315-458-3600

- Better Breathing
- Diabetes Self-Management
- Healthy Monday Syracuse
- Smoking Cessation
- Total Joint Replacement
- Worksite Wellness
- Cardiac Rehabilitation
- Early Intervention
- Pulmonary Rehabilitation
- Take Shape, SJH
- Wellness Place

Smoking Cessation Programs:

St. Joseph's Hospital
7246 Janus Park Drive
Liverpool, NY 13088
1-315-458-3600

Tobacco Free CNY-Cortland County
Cortland County Health Department
1-607-758-5501

Tobacco Free CNY-Tompkins County
Tompkins County Health Department
1-607-274-6712

Childbirth and New Family Classes:

St. Joseph's Hospital
7246 Janus Park Drive
Liverpool, NY 13088
1-315-458-3600

- Breast-Feeding Class
- Fit and Healthy Pregnancy Class
- Lamaze Weekend
- Newborn Care Class
- Labor Preparation Class
- Sibling Class
- Staying in Touch

Crouse Hospital
736 Irving Ave
Syracuse, NY 13210

- Childbirth Preparation
- Weekend Childbirth Preparation
- Childbirth Refresher
- Family Birth Program Orientation
- Siblings at Birth Class
- Big Brother/Big Sister Class
- Breastfeeding Preparation
- Baby Care Class
- Two's, Three's and More-Multiples Preparation
- Pediatric CPR and First Aid

Part 2: Your Benefits and Plan Procedures

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

BENEFITS

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. Molina Healthcare will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/ HIV testing and counseling; and specific self-referral services, including those you can get from within Molina

Healthcare and some that you can choose to go to any Medicaid provider of the service. Please call our member services department at 1-800-223-7242 (TTY: 711) if you have any questions or need help with any of the services below.

SERVICES COVERED BY Molina Healthcare

You must get these services from the providers who are in Molina Healthcare. All services must be medically or clinically necessary and provided or referred by your PCP. Please call our Member Services department at

1-800-223-7242 (TTY:711) if you have any questions or need help with any of the services below.

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye / hearing exams

Preventive Care

- well-baby care
- well-child care
- regular check-ups
- shots for children from birth through childhood
- access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- smoking cessation counseling.
- access to free needles and syringes
- HIV education and risk reduction

Maternity Care

- pregnancy care
- doctors/mid-wife and hospital services
- newborn nursery care
- screening for depression during pregnancy and up to a year after delivery

Home Health Care

- must be medically needed and arranged by Molina Healthcare.
- one medically necessary post-partum home health visit, additional visits as medically necessary for high-risk women.
- at least 2 visits to high-risk infants (newborns).
- other home health care visits as needed and ordered by your PCP/specialist.

Personal Care/Home Attendant/ Consumer Directed Personal Assistance Services (CDPAS)

- Must be medically needed and arranged by Molina Healthcare.
- Personal Care/Home Attendant – Help with bathing, dressing and feeding and help with preparing meals and housekeeping.
- CDPAS – Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you.
- If you want more information contact Molina Healthcare at 1-800-223-7242 (TTY: 711).

Personal Emergency Response System (PERS)

- This is an item you wear in case you have an emergency.
- To qualify and get this service you must be receiving personal care/home attendant or CDPAS services.

Adult Day Health Care Services

- Must be recommended by your PCP.
- Provides health education, nutrition, nursing and social services, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for dental and other specialty care.

AIDS Adult Day Health Care Services

- Must be recommended by your PCP.
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational and wellness/ health promotion activities.

Therapy for Tuberculosis

- This is help taking your medication for TB and follow up care.

Hospice Care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by Molina Healthcare.
- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

Children under age twenty-one (21) who are getting hospice services can also get medically needed curative services and palliative care.

If you have any questions about this benefit, you can call Member Services Department at 1-800-223-7242 (TTY: 711).

Dental Care

Molina Healthcare believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

How to Get Dental Services:

As part of your dental benefit, you will have a Primary Care Dentist, or PCD, in the Healthplex network of dentists. You will see your PCD for all of your general dental needs. Your PCD will refer you to a specialist for dental services when you need one.

- If you need to find a dentist or change your dentist, please call Healthplex at 1-800-468-9868 (TTY: 711), Monday through Friday, 8:00 AM to 6:00 PM. Customer Service Representatives are there to help you. Many speak your language or have a contract with Language Line Services.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.
- You can also go to a dental clinic that is run by an academic dental center without a referral. If you need help finding a dentist or a dental clinic that is run by an academic dental center, call the New York State Hotline at 1-800-541-2831.

Orthodontic Care

Molina Healthcare will cover braces for children up to age 21 who have a severe problem with their teeth, such as; can't chew food due to severely crooked teeth, cleft palette or cleft lip.

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider.
- eye exams, generally every two years, unless medically needed more often.
- glasses (new pair of Medicaid approved frames every two years, or more often if medically needed).

- low vision exam and vision aids ordered by your doctor.
- specialist referrals for eye diseases or defects.

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Enteral formula
- Emergency Contraception (6 per calendar year)
- Medical and surgical supplies

A pharmacy co-payment may be required for some people, for some medications and pharmacy items. There are no co-pays for the following members or services:

- Members younger than 21 years old.
- Members who are pregnant. Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- Members in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program.
- Members in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Family Planning drugs and supplies like birth control pills and male or female condoms.
- Generic co-pays (if Plan is waiving copay).
- Drugs to treat mental illness (psychotropic) and tuberculosis.

Prescription Item	Co-payment Amount	Co-payment Details
Brand name prescription drugs	$3.00/ $1.00/	1 co-pay charge for each new prescription and each refill
Generic prescription drugs	$1.00	
Over the counter drugs, such as for smoking cessation and diabetes	$0.50	

- There is a co-payment for each new prescription *and* each refill.
- If you have a co-pay, you are responsible for a maximum of $50 per calendar quarter
  - First quarter: January 1 – March 31
  - Second quarter: April 1 – June 30
  - Third quarter: July 1 – September 30
  - Fourth quarter: October 1 – December 31
- If you transferred plans during the calendar year, keep your receipts as proof of your co-payments or you may request proof of paid co-payments from your pharmacy. You will need to give a copy to your new plan.
- If you are unable to pay the requested co-pay you should tell the provider. The provider cannot refuse to give you services or goods because you are unable to pay the co-pay. However, unpaid co-pays are a debt you owe the provider.
- Certain medications may require that your doctor get prior authorization from us before writing your prescription. Yourdoctor can work with CVS Caremark to make sure you get the medications that you need. Molina Healthcare drug-specific request forms help simplify the process when you require prior authorization for a medication. Your provider can request a prior authorization on-line at www.MolinaHealthcare.com and fax completed form to CVS Caremark at 1-844-823-5479.

- You have a choice in where you fill your prescriptions.Youcan gotoanypharmacythat participateswithourplan.Formoreinformation on your options, please contact Member Services at 1-800-223-7242 (TTY: 711).

Hospital Care

- inpatient care
- outpatient care
- lab, x-ray, other tests

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called ***Post Stabilization Services.***
- For more about emergency services, see page 17.

Emergency Supply of Medication Assisted Treatment (MAT):

Within 24 hours; immediate authorization for 72- hour emergency supply; immediate access to 7-day supply for Substance User Disorder (SUD) treatment medication; immediate authorization of 7 day supply for opioid withdrawal/ stabilization.

Limits for physical, occupational and speech therapists do not apply if you are under age 21, you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.

Residential Health Care Facility Services (Nursing Home)

Covered nursing home services include:

- medical supervision;
- 24-hour nursing care;
- assistance with daily living;
- physical therapy;
- occupational therapy;
- speech-language pathology and other services.

To get these nursing home services:

- the services must be ordered by your physician, and
- the services must be authorized by Molina Healthcare.

Rehabilitation

Molina Healthcare covers short term, or rehabilitation (also known as “rehab”) stays, in a skilled nursing home facility.

Long Term Placement:

Molina Healthcare covers long term placement in a nursing home facility for members 21 years of age and older.

Long term placement means you will live in a nursing home.

When you are eligible for long term placement, you may select one of the nursing homes that are in Molina Healthcare’s network that meets your needs.

If you want to live in a nursing home that is not part of Molina Healthcare’s network, you must first transfer to another plan that has your chosen nursing home in its network.

Eligible Veterans, Spouses of Eligible Veterans, and **Gold Star Parents of Eligible Veterans** may choose to stay in a Veterans’ nursing home.

Molina Healthcare does not have a Veterans’ Home in its network. If you are an eligible Veteran, spouse of an eligible Veteran or a Gold Star Parent of an eligible Veteran and you want to live in a Veterans’ Home, we will help arrange your admission. You must transfer to another Medicaid Managed Care health plan that has the Veterans’ Home in its network.

Determining Your Medicaid Eligibility for Long Term Nursing Home Services

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or Molina Healthcare pay for long term nursing home services. The

LDSS will review your income and assets to determine your eligibility for long term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long-term nursing home care.

Questions

If you have any questions about these benefits, call our Member Services Department at 1-800-223-7242, (TTY: 711).

Additional Resources

If you have concerns about long term nursing home care, choosing a nursing home, or the effect on your finances, there are additional resources to help.

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org.
- New York State Office for the Aging
  - Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0501.
  - NY CONNECTS is a link to long term service and supports. Call 1-800-342-9871 or visit www.nyconnects.ny.gov.
- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit www.health.ny.gov/facilities/nursing/rights/.

BEHAVIORAL HEALTH CARE

Behavioral health care includes mental health and substance use treatment and rehabilitation services. All of our members have access toservicestohelpwithemotionalhealth,ortohelp withalcoholorothersubstanceuseissues.These services include:

Mental Health Care

- Day treatment
- Clinic continuing day treatment
- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services if you are in a community home or in family-based treatment
- Continuing day treatment
- Personalized Recovery Oriented Services
- Assertive Community Treatment Services
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services

Crisis Services

- Medically Managed Withdrawal Management
- Medically Supervised Withdrawal Management (Inpatient/Outpatient*)

Inpatient addiction treatment services (hospital or community based)

Residential addiction treatment services

- Stabilization in Residential Setting
- Rehabilitation in Residential Setting

Outpatient addiction treatment services

- Intensive Outpatient Treatment
- Outpatient Rehabilitation Services
- Outpatient Withdrawal Management
- Medication Assisted Treatment

Opioid Treatment Programs (OTP) (Inpatient/Outpatient*)

- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services
  - Stabilization in Residential Setting
  - Rehabilitation in Residential Setting
- Outpatient addiction treatment services
  - Intensive Outpatient Treatment
  - Outpatient Rehabilitation Services
  - Outpatient Withdrawal Management
  - Medication Assisted Treatment
- Opioid Treatment Programs (OTP)

Children's Family Treatment and Support Services (CFTSS)

You may already get similar services with your State Medicaid Card. Starting on the dates below, use your Molina Healthcare benefit card to get the service.

Use your Molina Healthcare benefit card to get Children and Family Treatment and Support Services. These services include:

- Crisis Intervention (CI)
- Other Licensed Practitioner (OLP). This benefit lets you get individual, group, or family therapy where you are most comfortable.
- Psychosocial Rehabilitation (PSR). This benefit helps you relearn skills to help you in your community. This service was called "Skill Building."
- Community Psychiatric Supports and Treatment (CPST). This benefit helps you stay in your home and communicate better with family, friends and others. This service was called "Intensive In Home Services," "Crisis Avoidance Management &Training," or "Intensive In Home Supports and Services." If you are under 21 years old and have federal Social Security Insurance disability status or have been determined Social Security Insurance- Related by New York State, use your State Medicaid Card for these Children's Family Treatment and Support Services.
- Family Peer Support Services (FPSS)
- Youth Peer Support and Training (YPST)

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- FQHC
- Family Planning Services

Behavioral Health Services for Children and Youth:

Effective July 1, 2019, members under age 21 will be able to get these services:

Substance Use Disorder Services

Crisis Services

- Medically Managed Withdrawal Management
- Medically Supervised Withdrawal Management (Inpatient/Outpatient*)

Inpatient addiction treatment services (hospital or community based)

Residential addiction treatment services

- Stabilization in Residential Setting
- Rehabilitation in Residential Setting

Outpatient addiction treatment services

- Intensive Outpatient Treatment
- Outpatient Rehabilitation Services
- Outpatient Withdrawal Management
- Medication Assisted Treatment

Opioid Treatment Programs (OTP)

- Office of Mental Health (OMH) Outpatient Services OMH designated Serious Emotional Disturbance (SED) Clinic Services
- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Personalized Recovery Oriented Services (PROS) Partial Hospitalization
- Psychiatric Services
- Psychological Services
- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed
- Inpatient Psychiatric Services

Children's Home and Community Based Services (HCBS)

Children's HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS is provided where children/youth and families are most comfortable and supports them as they work towards goals and achievements.

Who can get Children's HCBS? Children's HCBS are for children and youth who:

- Need extra care and supports to remain at home/in the community
- Have complex health, developmental and/or behavioral health needs.
- Want to avoid going to the hospital or a long-term care facility
- Are eligible for HCBS and participate in the
- Children's Waiver

Members under age 21 will be able to get these services from their health plan:

- Community Habilitation
- Day Habilitation
- Caregiver/Family Support and Services
- Community Self Advocacy Training and Support
- Prevocational Services – *must be age 14 and older*
- Supported Employment – *must be age 14 and older*
- Respite Services (Planned Respite and Crisis Respite)
- Palliative Care
- Environmental Modifications
- Vehicle Modifications
- Adaptive and Assistive Equipment

National Diabetes Prevention Program (NDPP)

If you are at risk for developing Type 2 diabetes, Medicaid Managed Care covers services that may help.

Medicaid Managed Care will cover diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover

22 NDPP group training sessions over the course of 12 months.

The National Diabetes Prevention Program is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility

You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And, you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, or
- You have been previously diagnosed with gestational diabetes, or
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test. Talk to your doctor to see if you qualify to take part in the NDPP.

Infertility Services

Some infertility drugs are covered (limited to coverage for 3 cycles of treatment per lifetime).

Other services covered are related to prescribing and monitoring the use of such drugs including:

- Office visits
- X-ray of the uterus and fallopian tubes
- Pelvic Ultrasound
- Blood Testing

Benefits You Can Get From Molina Healthcare OR With Your Medicaid Card

For some services, you can choose where to get the care. You can get these services by using your Molina Healthcare membership card. You can also go to providers who will take your Medicaid Benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at 1-800-223-7242 (TTY: 711).

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP.

You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

HIV and STI Screening

You can get this service any time from your PCP or Molina Healthcare doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. Toaccess free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

TB Diagnosis and Treatment

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Benefits Using Your MEDICAID CARD Only

There are some services Molina Healthcare does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

Emergency and/or non-emergency medical transportation will be covered by regular Medicaid. To get nonemergency transportation, you or your provider must call Medical Answering Services (MAS) at the number below:

- Medical Answering Service at 1-855-733-9398 for members who live in Tioga County
- Medical Answering Service at 1-855-852-3294 for members who live in Broome County

If possible, you or your provider should call Medical Answering Service (MAS) at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

If you have an emergency and need an ambulance, you must call 911.

Developmental Disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Services NOT Covered:

These services are not available from Molina Healthcare *or Medicaid.* If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Services from a provider that is not part of Molina Healthcare, unless it is a provider you are allowed to see as described elsewhere in this handbook or Molina Healthcare or your PCP send you to that provider
- Services for which you need a referral (approval) in advance and you did not get it
- Drugs when used to treat erectile dysfunction

You may have to pay for any service that your PCP does not approve. Or, if before you get a service, you agree to be a "private pay" or "self-pay" patient you will have to pay for the service. This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of Molina Healthcare

If You Get a Bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Molina

Healthcare at 1-800-223-7242 (TTY: 711) right away. Molina Healthcare can help you understand why you may have gotten a bill. If you are not responsible for payment, Molina Healthcare will contact the provider and help fix the problem for you.

You have the right to ask for fair hearing if you think you are being asked to pay for something Medicaid or Molina Healthcare should cover. See the Fair Hearing section later in this handbook.

If you have any questions, call Member Services at 1-800-223-7242 (TTY: 711).

Service Authorization

Prior Authorization:

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization.** You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

PCP's or specialists must call the Provider Assistance Line at 1-877-872-4716:

- No prior authorization is needed for Substance Abuse Disorder (SUD) services .
- **Emergency Supply of Medication** Assisted Treatment (MAT): Within 24 hours; immediate authorization for 72- hour emergency supply; immediate access to 7-day supply for Substance User Disorder (SUD) treatment medication ; immediate authorization of 7 day supply for opioid withdrawal/ stabilization.
- Services from non-participating Providers
- Sleep Studies
- Genetic testing
- CPAP/BIPAP/Oxygen/TENS Units
- Durable Medical Equipment that costs more than $500
- Surgery not performed in the doctor's office
- Specific Radiology Procedures (MRI, Selected CT Scans and Nuclear Medicine Studies)

Asking for approval of a treatment or service is called **a service authorization request.** To get approval for these treatments or services, you need to:

You or your doctor may call our toll-free Member Services number at 1-800-223-7242 (TTY: 711) or send your request in writing to:

Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212

What happens after we get your service authorization request:

The health plan has a review team to be sure you get the services we promise. We check that the service you are asking for is covered under your health plan. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, we use to make decisions about medical necessity.

After we get your request we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the review must be faster;
- You are asking for more a service you are getting right now.

In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.(See also the Plan Appeals and Fair Hearing sections later in this handbook).

Timeframes for prior authorization requests:

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- **Standard review:** We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital, and you ask for home health care, we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least
- 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking foran outpatient prescription drug we
- will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

If we need more information to make either a standard or fast track decision about your service request we will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-223-7242 (TTY: 711) or writing to:

Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the Plan Appeal section later in this handbook.

Other Decisions About Your Care:

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called retrospective review. We will tell you if we make these decisions.

Timeframes for other decisions about your care:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and permanent nursinghome care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills.

You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at 1-800-223-7242 (TTY: 711) if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary.** The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many-or even none at all. This is called **capitation.**
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service.** This means they get a Plan-agreed-upon fee for each service they provide.

You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members.

If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-800-223-7242 (TTY: 711) to find out how you can help.

Information From Member Services

- Here is information you can get by calling Member Services at 1-800-223-7242 (TTY: 711)
- A list of names, addresses, and titles of Molina Healthcare's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/ balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about member complaints about Molina Healthcare.
- How we keep your medical records and member information private.
- In writing, we will tell you how Molina Healthcare checks on the quality of care to our members.

- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by Molina Healthcare.
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of Molina Healthcare.
- If you ask, we will tell you: 1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 2) information on the type of incentive arrangements used; and 3) whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

Keep Us Informed

Call Member Services at 1-800-223-7242 (TTY: 711) whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you or your children

If you no longer get Medicaid, check with your local Department of Social Services. You may be able to enroll in another program.

DISENROLLMENT AND TRANSFERS

1. If YOU want to leave the Plan

You can try us out for 90 days. You may leave Molina Healthcare and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in Molina Healthcare for nine more months, unless you have a good reason (good cause).

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the LDSS all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.

To change plans:

- Call the Managed Care staff at your local Department of Social Services.
- If you live in Allegany, Broome, Cattaraugus, Chautauqua, Chenango, Cortland, Erie, Genesee, Livingston, Monroe, Onondaga, Ontario, Orleans, Seneca, Tioga, Tompkins, Wayne and Wyoming Counties, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

You may be able to transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. Molina Healthcare will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

2. You Could Become Ineligible for Medicaid Managed Care

- You or your child may have to leave Molina Healthcare if you or the child:
  - move out of the County or service area
  - change to another managed care plan
  - join an HMO or other insurance plan through work
  - go to prison
  - otherwise lose eligibility
- Your child may have to leave Molina Healthcare or *change plans if he or she:
  - joins a Physically Handicapped Children's Program, or
  - is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services
  - * is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan.
- **If you have to leave** Molina Healthcare **or ecome ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home.** Call New York Medicaid Choice at 1-800-505-5678 right away if this happens.

3. We Can Ask You to Leave Molina Healthcare

You can also lose your Molina Healthcare membership, if you often:

- refuse to work with your PCP in regard to your care;
- don't keep appointments;
- go to the emergency room for non- emergency care;
- don't follow Molina Healthcare's rules;
- do not fill out forms honestly or do not give true information (commit fraud);
- cause abuse or harm to plan members, providers or staff; or
- act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

Plan Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization.** Asking for approval of a treatment or service is called a **service authorization request.** This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination.**

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file a Plan Appeal:

If you think ourdecision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal.**

- Youhave 60 calendar days from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services 1-800-223-7242 (TTY:711) if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continuewhile appealing a decisionabout your care:

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. **You must ask for your Plan Appeal:**

- Within **ten days** from being told that your care is changing; or
- By the date the change in services is scheduled to occur, whichever is later.

If your Plan Appeal results in another denial you may have to pay for the cost of any continued benefits that you received.

You can call, write, or visit us to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors'letters or otherinformation that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documentswe usedtomakethelnitialAdverse Determination. If your Plan Appeal is fast tracked, there maybe a short time to give us information you want us to review.Youcan askto see these documents or ask for a free copy by calling 1-800-223-7242 (TTY: 711).

Give us your information and materials by phone, fax, mail, online, or in person

Phone.....1-800-223-7242, TTY: 711

Fax.....1-844-879-4471

Mail.....Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212

Online : https://member.molinahealthcare.com/Member/Login

In Person .....Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

If you are asking for out of network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
  1. a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
  2. two medical or scientific documents that prove the service youareaskingforismorehelpfulto you and will not cause you more harm than the service the plan can providefroma participatingprovider.
- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:
  1. a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and

2. that recommends an out of network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call Molina Healthcare at 1-800-223-7242 if you are not sure what information to give us.
- Plan appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a Final Adverse Determination.
- If you think our Final Adverse Determination is wrong:
  - you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
  - for some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
  - you may file a complaint with the New York State Department of Health at 1-800-206-8125.

Time frames for Plan Appeals:

- **Standard plan appeals:** If we have all the information we need we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- **Fast track plan appeals:** If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for a Plan Appeal.
  - We will tell you within 72 hours if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your Plan Appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or
- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast track decision about your Plan Appeal we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest;
- Make a decision no later than 14 days from the day we asked for more information.

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-223-7242 (TTY: 711) or writing.

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your plan appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1. not medically necessary;
2. experimental or investigational;
3. not different from care you can get in the plan's network; or
4. available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

If your original denial was because we said:

- the service was not medically necessary; or
- the service was experimental or investigational; or
- the out-of-network service was not different from a service that is available in our network; or
- the out-of- network service was available from a plan provider who have the training and experience to meet your needs, or
- we do not tell you our decision about your Plan Appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

In some cases you may be able to continue the services while you wait for your plan appeal to be decided. **You may be able to continue the services thatarescheduledtoendorbereducedif you ask for a fair hearing:**

- Within **ten days** from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your fair hearing results in another denial you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

External Appeals

You have other appeal rights if we said the service you are asking for was:

- not medically necessary;
- experimental or investigational;
- not different from care you can get in the plan's network; or
- available from a participating provider who has the correct training and experience to meet your needs.

You can ask New York State for an independent External Appeal. This is called an **External Appeal** because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease.

You do not have to pay for an External Appeal. Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or

- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have 4 **months** after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-800-223-7242 (TTY: 711) if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882.
- Go to the Department of Financial Service's website at www.dfs.ny.gov.
- Contact the health plan at 1-800-223-7242 (TTY: 711).

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health; or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal.** The external appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, the plan will continue to pay for your stay if:

- you ask for a fast track Internal Appeal within 24 hours; AND
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a fair hearing from New York State if:

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving Molina Healthcare.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted.

You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with Molina Healthcare. If Molina Healthcare agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits.
- You are not happy we decided to:
  - reduce, suspend or stop care you were getting; or
  - deny care you wanted;
  - deny payment for care you received; or
  - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later. However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone – call toll-free 1-800-342-3334
2. By fax – 1-518-473-6735
3. By internet – www.otda.state.ny.us/oah/forms.asp
4. By mail –
   NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision Molina Healthcare made, we must send you a copy of the **evidence packet.** This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-800-223-7242 (TTY: 711) to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

COMPLAINT PROCESS

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can call Member Services 1-800-223-7242 (TTY: 711) if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

Complaint Unit, Bureau of Consumer Services
OHIP DHPCO 1CP-1609
New York State Department of Health
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with Our Plan:

You can file a complaint, or you can have someone else, likea familymember,friend,doctororlawyer,filethe complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you. To file by phone, call Member Services at 1-800-223-7242 (TTY: 711), Monday through Friday, 8:00 AMto 6:00 PM. If you callus afterhours, leave a message. We will call you back the next work day.If we need more informationto make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212

What happens next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call Molina Healthcare at 1-800-223-7242 (TTY: 711) if you are not sure what information to give us.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals:

If you disagree with a decision we made about your complaint, you or someone you trust can file a complaint appeal with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- The complaint appeal must be made in writing. If you make an complaint appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 work days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information, we need you will know our decision in 30 work days. If a delay would risk your health you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can

file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of Molina Healthcare, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from Molina Healthcare.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will notbe shared with anyoneexceptas required by law, contract, or with your approval.
- Use the Molina Healthcare complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Your Responsibilities

As a member of Molina Healthcare, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

Advance Directives

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of

treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy

With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR

You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card

This wallet sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

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To allow space for local adaptations.)

Important Phone Numbers

Your PCP

Your Health Plan: Molina Health care of New York, Inc. (Molina Health care)

Member Services.....1-800-223-7242 TTY: 711

Your Nearest Emergency Room

New York State Department of Health (Complaints) 1-800-206-8125

1-CVS Caremark Pharmacy 1-800-223-7242

New York Medicaid Choice.....1-800-505-5678

New York State Department of Health (Complaints) 1-800-206-8125

Ombudsman Program (Mailbox and Hot line) 1-888-614-5400

Ombuds@oasas.ny.gov

Important Websites

Molina Healthcare of New York, Inc.
www.molinahealthcare.com

New York State Department of Health
https://www.health.ny.gov/

New York State Office of Mental Health
https://omh.ny.gov/

Office of Addiction Services and Supports
https://oasas.ny.gov

Long Term Care Ombudsman Program
https://aging.ny.gov/long-term-care-ombudsman-program

Department of Social Services:

Allegany County:
1-585-268-9622

Broome County:
1-607-778-8850

Cattaraugus County:
1-716- 373-8065

Chautauqua County:
1-716-753-4421

Chenango County:
1-607-337-1500

Cortland County:
1-607-753-5324

Erie County:
1-716-858-8000

Genesee County:
1-585-344-2580

Livingston County:
1-585-243-7300

Monroe County:
1-585-753-2750

Onondaga County:
1-315-435-2928

Ontario County:
1-585-396-4060

Orleans County:
1-585-589-7000

Seneca County:
1-315-539-1800

Tioga County:
1-607-687-8300

Tompkins County:
1-607-274-5667

Wayne County:
1-315-946-4881

Wyoming County:
1-585-786-8900

Medical Answering Services (MAS):

Allegany County:
1-866-271-0564

Broome County:
1-855-852-3294

Cattaraugus County:
1-866-371-4751

Chautauqua County:
1-855-733-9405

Chenango County:
1-855-733-9396

Cortland County:
1-855-733-9397

Erie County:
1-800-651-7040

Genesee County:
1-855-733-9404

Livingston County:
1-888-226-2219

Monroe County:
1-866-932-7740

Onondaga County:
1-855-852-3287

Ontario County:
1-855-733-9402

Orleans County:
1-866-260-2305

Seneca County:
1-866-753-4437

Tioga County:
1-855-733-9398

Tompkins County:
1-866-753-4543

Wayne County:
1-855-852-3295

Wyoming County:
1-855-733-9403


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HEALTHCARE