Your Member Handbook

COMMONWEALTH OF VIRGINIA

Medicaid

MolinaHealthcare.com

MOLINA® HEALTHCARE | CardinalCare Virginia's Medicaid Program

Welcome! Thank you for being a Molina Healthcare member.

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

To access the tools and resources that will help you take advantage of your benefits, register on the MyMolina Member Portal and download the Mobile App to access these benefits on the go. Scan the QR codes below to get started.

Member portal

Mobile App

Do you need a printed copy of this handbook or a copy of your member ID card? The self-service tools will help you access the information you need faster. Medicaid and Family Access to Medical Insurance Security (FAMIS) Plans are health insurance programs funded by the state and the federal government. They are run by the Virginia Department of Medical Assistance Services (DMAS or "the Department"). For more information, visit **Dmas.virginia.gov** and **Dmas.virginia.gov/for-members/cardinal-care**. Monthly income limits for eligibility vary by program. For more eligibility information, visit **Coverva.org**.

This member handbook explains benefits and how to access services for Molina Healthcare's Medicaid/FAMIS program.

Access our easy-to-use self-service options anytime, anywhere.

There are also many self-service options to get your information faster. The MyMolina Member Portal and Mobile App allow you to update your contact information, request a new ID card, get health reminders, view your health history, and more. You can also learn more about your Molina Healthcare benefits on our website at **MolinaHealthcare.com**.

Questions?

If you have questions after you access the self-service options, call Member Services at **(800) 424-4518** (TTY/TDD: 711) 8 a.m. to 8 p.m., seven days a week. You can also visit our website at **MolinaHealthcare.com** or call your Care Manager.

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Getting started

Are you new to Molina Healthcare? If so, take these steps to get started and get the most from your plan:

1. Review your Welcome Kit

Your Welcome Kit contains important information about your new health plan. It includes a Quick Start Guide that lists important first steps for getting and using your benefits and managing your plan.

You should have received your Molina member ID card along with your Welcome Kit. This card replaces your Medicaid card. There is one card for every member of your family who is in our plan. Please keep it with you at all times.

If you haven't received your member ID card, follow the instructions below to register for the member portal and access the self-service options at MyMolina.com.

2. Register for the Member Portal (My Molina)

My Molina is your personalized member portal. Log in using your member ID number. Once there, you can change your primary care provider (PCP), view your service history, request a new ID card and more! You can connect from any device.

For help on the go, download the MyMolina mobile app.

3. Talk about your health

Understanding your health helps us identify how to give you the best possible care for you. We'll call you for a short survey about your health history. Please let us know if your contact information changes.

4. Get to know your PCP

PCP means primary care provider. Your PCP is your main doctor.

Schedule your first PCP visit within the first [60] days. The purpose of this visit is to start a relationship with your PCP. Your PCP will get to know your health history and how to best treat you. Think of your PCP as your medical home – the place that knows you the best!

To choose or change your PCP, go to MyMolina.com. or the My Molina Mobile App.

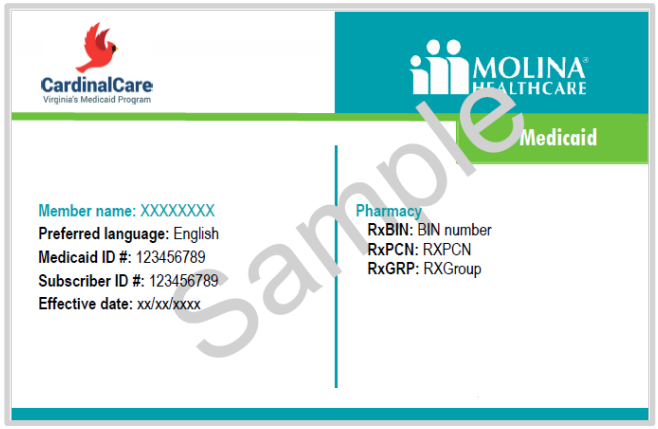
5. Get to know your benefits

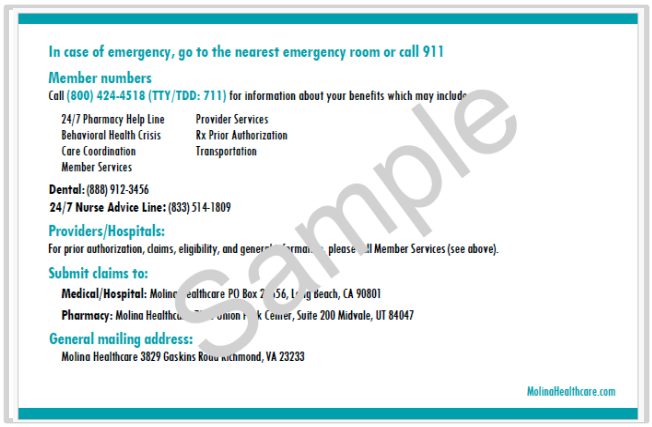
With Molina, you get all your Medicaid benefits PLUS extra ones at no cost to you. We offer gift card rewards, transportation, health education and more. And we are committed to your care.

Your Membership

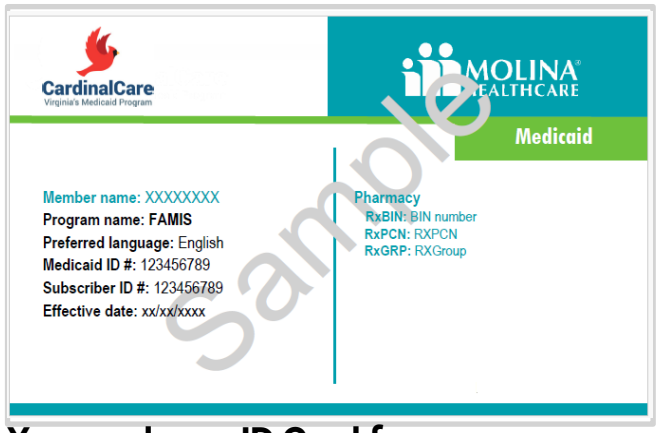
You'll get one ID card for each member in your family.

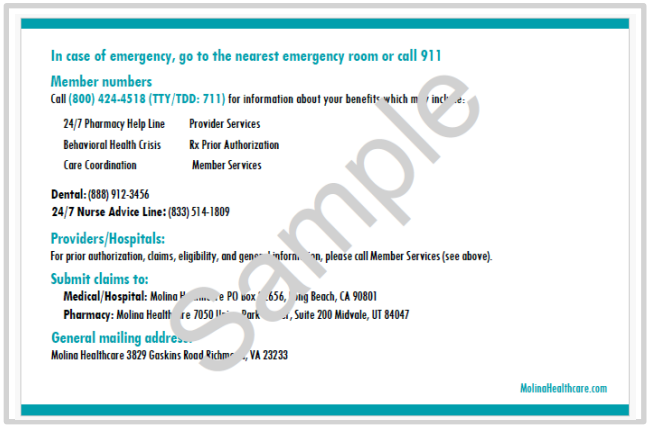
Medicaid sample ID card





FAMIS sample ID card





You need your ID Card for:

- Doctor, specialist and other provider visits
- Hospital stays
- The emergency room
- Prescriptions and medical supplies
- Urgent care centers
- Getting medical tests
- Accessing waiver services or starting with a services or starting with a new waiver provider] new waiver provider

Important contact information

Below is a list of important phone numbers you may need. If you are not sure who to call, contact Member Services for help. This call is free. Free interpreter services are available in all languages for people who do not speak English.

Entity name	Contact information
Molina Healthcare Member Services	**(800) 424-4518** (TTY/TDD: 711) MolinaHealthcare.com 8 a.m. to 8 p.m., Seven days a week Virginia Medicaid Managed Care Helpline at (800) 643-2273 (TTY/TDD: 800-817-6608)
Molina Healthcare Medical Advice Line	(833) 514-1809 TTY/TDD: 711 **24 hours a day. Seven days a week**
Molina Healthcare Behavioral Health Crisis Line	**(833) 514-1809** (TTY/TDD: 711) Call or text 988 or chat at 988Lifeline.org 24 hours a day. Seven days a week
Addiction and Recovery Treatment Services (ARTS) Medical Advice Line	(800) 424-4518 (TTY: 711) 8 a.m. to 8 p.m., seven days a week
Department of Behavioral Health and Developmental Services (DBHDS) for DD Waiver Services	My Life My Community Helpline **(844) 603-9248** TTY/TDD: (804) 371-8977 Monday through Friday, 9 a.m. to 4:30 p.m. **https://www.mylifemycommunityvirginia.org/**
Cardinal Care Dental Benefits Administrator	**(888) 912-3456** TTY/TDD: (800) 466-7566 Monday through Friday, 8:00 a.m. to 6:00 p.m. **https://dentaquest.com/state-plans/regions/virginia/**
Molina Healthcare general transportation services	**(833) 273-7416** TTY/TDD: 711 24 hours a day, 7 days a week, including holidays

Entity name	Contact information
Molina Healthcare Vision Services	**Vision Services Plan (VSP)** **(800) 877-7195** (TTY/TDD: (800) 428-4833) Monday - Saturday, 9:00 a.m. - 8:00 p.m.
DMAS	Department at Department of Medical Assistance Services dmas.virginia.gov
Cover Virginia	**(833) 5-CALLVA**
Molina Healthcare Transportation Services	**Access2Care** **(877) 790-9472** or **833-273-7416** Monday through Friday; 8 a.m. to 6 p.m.
Cardinal Care Managed Care Transportation for Developmental Disability Waiver Services contractor	**(866) 386-8331** TTY/TDD: (866) 288-3133 Dial 711 to reach a TRS operator 24 hours a day, seven days a week
Cardinal Care Managed Care Enrollment Helpline	**(800) 643-2273** TTY/TDD: (800) 817-6608 Monday through Friday, 8:30 a.m. to 6:00 p.m.
Department of Health and Human Services Office for Civil Rights	**(800) 368-1019** TTY/TDD: (800) 537-7697 hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	**(800) 552-5019** TTY/TDD: (800)-464-9950 elderrightsva.org

Staying connected

Have you moved, changed phone numbers, or received a new email address? It is important to let us know so that you keep getting high-quality health insurance. The Department and Molina Healthcare need your current mailing address, phone number, and email address so that you do not miss any important updates and receive information about changes to your health insurance.

You can update your contact information today:

- By calling **Cover Virginia** at **(833) 5-CALLVA**.
- Online at **Commonhelp.virginia.gov**.
- By calling Molina Member Services at **(800) 424-4518** TTY/TDD: 711
- By calling your local Department of Social Services (DSS).

Update your contact info today.

Make sure to get the latest news about your Medicaid health insurance.

Molina Healthcare Overview

Health plan enrollment

You are successfully enrolled in Molina Healthcare (Molina). Molina, a Cardinal Care Medicaid/FAMIS managed care plan (a "health plan"), that covers your health care and provides care management. A health plan is an organization that contracts with doctors, hospitals, and other providers to work together to get you the health care you (the member) need.

If you move out of state, you will no longer be eligible for Molina coverage in Virginia, but you may be eligible for the Medicaid program in your state. If you have questions about your eligibility, contact your local DSS or call Cover Virginia at (833) 5-CALLVA (TTY/TDD: 1-888-221-1590). This call is free.

Member Services is available to help if you have any questions or concerns. Call **(800) 424-4518** (TTY/TDD: 711) 8 a.m. to 8 p.m., seven days a week, or visit **MolinaHealthcare.com**.

You can change your health plan:

- For any reason during the first 90 calendar days of enrollment.
- For any reason, once a year during your open enrollment period.
- For “good cause” reasons determined by DMAS Examples include poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care. This includes OB care. If you are pregnant and your OB provider does not participate with Molina and does participate with Medicaid fee-for-service (FFS), you can ask to get coverage through Medicaid FFS until after the delivery of your baby.

Call the Cardinal Care Managed Care Enrollment Helpline at **(800) 643-2273 (TTY/TDD: (800) 817-6608)** Monday through Friday, 8:30 a.m. to 6 p.m. for information about your open enrollment period or “good cause”, or to help you choose or change your health plan. You can also visit **VirginiaManagedCare.com**. This service is free. FAMIS members can call Cover Virginia at **(833) 5-CALLVA** to change health plans.

Welcome Packet

You should have received a welcome packet that includes your Member ID Card, information on Molina's Provider Directory, and the Preferred Drug List. If you did not receive your welcome packet, call Molina's Member Services. [Information on (1) other ways to access these resources if the Member did not receive them or wants to access them electronically – e.g., through a mobile application; and (2) other resources sent to the Member].

Molina Healthcare Member ID Card

You may have more than one health insurance card. In addition to your Molina Member ID card, you should also have your Commonwealth of Virginia Medicaid/FAMIS ID card. Keep this card to access services that are covered by DMAS under Medicaid. If you have Medicare and Medicaid, show your Medicare card and Molina Member ID Card when you receive services. If you have coverage with a private (non-Medicaid) insurance company, show your private insurance ID Card and your Molina Member ID Card when you receive services.

Molina Healthcare Provider Directory

The provider directory lists providers and pharmacies participating in the Molina Healthcare network of contracted providers. It also includes information on each provider's accommodations for members with disabilities or who do not speak English.

While you are a member of our plan, and in most cases, you must use one of our network providers to get covered services.

You may ask for a paper copy of the provider and pharmacy directory by calling Member Services at (800) 424-4518. You can also see or download the provider and pharmacy directory at **MolinaHealthcare.com**. Your provider directory lists our network's doctors, hospitals, pharmacies, and other services and supports. In this directory, you can find provider names, addresses, phone numbers, and other important information about our network providers.

Preferred Drug List

This list tells you which prescription drugs are covered by Molina and DMAS. It also tells you if there are any rules or restrictions on the drugs, like a limit on the amount you can get (see the *Your Prescription Drugs* section).

Sometimes, members might need a special permission called an "override" to get their medicine from a pharmacy that's not usually covered: 1) If you're in foster care or don't live in your regular home and need medicine, you can get an override so you can get your medicine once a month from any pharmacy. 2) If you just joined a new health plan, you can get medicine for 30 days from any pharmacy in your first month. 3) If you really need medicine quickly for an emergency. 4) If your medicine is very special and not many pharmacies have it, you can still get it while waiting for your usual pharmacy to be ready to give you this medicine. 5) If you need medicine for family planning, which is a rule from the government. 6) If there isn't a pharmacy that works with your health plan close to your house (like 30 miles away), or for other important reasons your health plan agrees with. You have to call the pharmacy help desk to ask for this special permission.

Call Molina's Member Services to find out if your drugs are on the list or check online at **MolinaHealthcare.com**. Molina can also mail you a paper copy at your request.

Other insurance

You may have more than one health insurance plan. Medicaid pays for services after your other insurance plans have paid your provider. This means that if you have other insurance, are in a car accident, or are injured at work, your other insurance or worker's compensation must pay for your services first. Let Member Services know if you have other insurance so Molina can coordinate your benefits. The **Virginia Insurance Counseling and Assistance Program (VICAP)** can also help. Call **(800) 552-3402** (TTY/TDD: 711) for health insurance counseling available to Medicare recipients. This call is free.

Your PCP

Molina Healthcare Provider Network

It is important that the providers you choose accept Cardinal Care members and participate in Molina's network. The provider network includes access to care 24 hours a day, seven days a week.

Molina provides you with a choice of providers near you. If you live in an urban area, you should not have to travel more than 15 miles or 30 minutes to receive services. If you live in a rural area, you should not have to travel more than 30 miles or 45 minutes to receive services. To find providers, such as primary care providers (PCPs), specialists, and hospitals, you can:

- Search for providers in the provider directory (see the *Molina Healthcare Overview* section).
- Call Member Services at **(800) 424-4518 (TTY/TDD: 711)** or visit us at **MolinaHealthcare.com**.

Find providers and facilities on **SapphireThreeSixtyFive.com**. Get a printed or machine-readable copy of the directory.

How to get care from other network providers

Our provider network includes access to care 24 hours a day, 7 days per week. It includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community-based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers, and other types of providers. Molina provides you with a choice of providers, and they are located so you do not have to travel far to see them. There may be exceptional circumstances requiring longer travel time; however, that should be only on rare occasions.

You do not need a referral or service authorization to get:

- Care from your primary care provider (PCP).
- Family planning services and supplies.
- Routine women's health care services like breast exams, screening mammograms, pap tests, and pelvic exams, as long as you get them from a network provider.
- Emergency or urgently needed services.
- Routine dental services.
- Services from Indian health providers if you are eligible.
- Other service for member with special health care needs as determined by Molina.

See below for more information about when a provider leaves the network and times when you can get care from out-of-network providers.

Primary Care Providers (PCPs)

Your PCP is a doctor or nurse practitioner who helps you get and stay healthy. Your PCP will provide and coordinate your health care services. You should see your PCP:

- For physical exams and routine checkups.
- For preventive care services.
- When you have questions or concerns about your health.
- When you are not feeling well and need medical help.

To help your PCP get to know you and your medical history, you should have your past medical records sent to your PCP's office. Contact Molina's Member Services or your Care Manager for help.

Choosing your PCP

You have the right to choose a PCP in the Molina network. Review your provider directory to find a PCP in your community who can best meet your healthcare needs. You can also call Member Services or your care manager for help. If you do not choose a PCP by the 25th day of the month before your health coverage begins, Molina will assign you a PCP. Molina will notify you in writing of your assigned PCP.

You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) – cares for children and adults.
- Gynecologist (GYN) – cares for women
- Internal medicine doctor (also called an internist) – cares for adults
- Nurse Practitioner (NP) – cares for children and adults
- Obstetrician (OB) – cares for pregnant women
- Pediatrician – cares for children

If you already have a PCP not in the network, you can continue seeing them up to 30 days after enrolling in Molina Healthcare. For individuals who are pregnant or have significant health or social needs, you can continue seeing your PCP for up to 60 days after enrolling. If you do not choose a PCP in our network after the 30-day or 60-day period, Molina will assign you a PCP. If you have a Medicare-assigned PCP, you do not have to choose one in our network. Call Member Services or your care manager for help with selecting your PCP and coordinating your care.

Changing your PCP

You can change your PCP at any time. If you have not chosen a PCP by the 18th of the month before your effective date of coverage, Molina will assign one for you. You may call Member Services anytime to change your PCP or to choose another PCP in the Molina network.

Specialists

If you need care that your PCP cannot provide, Molina may refer you to a specialist. A specialist is a provider with additional training on services in a specific area of medicine, like a surgeon. The care you receive from a specialist is called specialty care. If you need ongoing specialty care, your PCP may be able to refer you for a specified number of visits or length of time (a "standing referral").

Out-of-state providers

The care you can get from out-of-state providers is limited to:

- Necessary emergency, crisis, or post-stabilization services.
- Special cases in which it is common practice for those living in your locality to use medical resources in another state.
- Medically necessary and required services that are not available in-network and within the state of Virginia.
- Periods of transition (until you can get timely services from a network provider in the state).
- Out-of-state ambulances for facility-to-facility transfers.

Molina may need to give you authorization to see a provider who is out-of-state. Molina does not cover any health care services outside of the U.S.

When a provider leaves the network

If your PCP leaves the Molina network, Molina will let you know by the later of thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. Molina will help you find a new PCP. If one of your other providers is also leaving the network, contact Member Services or your care manager for help finding a new provider to manage your care. You have the right to:

- Ask that medically necessary treatment is not interrupted, and for Molina to work with you to ensure that it continues.
- Get help selecting a new qualified provider.
- File a complaint. See the *Appeals and Complaints* section or request a new provider if you feel Molina has not replaced your previous provider with a qualified provider, or that your care is not being appropriately managed.

Getting care outside of the Molina Healthcare network

You can get the care you need from a provider outside of the Molina network in any of the

following circumstances:

- If Molina does not have a network provider to give you the care you need.
- If a specialist you need is not located close enough to you (within 30 miles in urban areas or 60 miles in rural areas).
- If a provider does not provide the care you need because of moral or religious objections.
- If Molina approves an out-of-network provider.
- If you are in a nursing facility when you enroll with Molina, and the nursing facility is out- of-network.
- If you get emergency care or family planning services from a provider or facility that is out-of-network. You can receive emergency treatment and family planning services from any provider, even if the provider is not in the Molina network. This care is free.

If you were previously enrolled in Virginia's Medicaid program but are new to Molina, you have the right to see your old providers and access prescription drugs or other necessary medical supplies for up to 60 days. This period is also extended to 60 days if you are pregnant or have significant health or social needs.

After 60 days, depending on the Plan, you will need to visit providers who are part of the Molina network. However, if the Plan extends the timeframe for you, then you can continue seeing your current providers. If you face any difficulty finding a network provider, you can call Member Services or your care manager for assistance. For additional information about your care manager, please refer to the *Care Coordination and Care Management* section.

Choices for nursing facility members

If you are in a nursing facility at the time you enroll with Molina, you may choose to:

- Remain in the facility as long as you remain eligible for nursing facility care.
- Move to a different nursing facility.
- Receive services in your home or other community-based settings.

Making appointments with providers

To schedule an appointment with your healthcare provider, please call their office directly. If you need assistance with scheduling, you can call Member Services at **(800) 424-4518** (TTY/TDD: 711). If you require transportation to your appointment and meet certain criteria,

Molina offers non-emergency transportation services. To request transportation, call the reservation line at **(833) 273-7416**. Please note that Molina requires a 72-hour advanced notice period for transportation requests.

In case of a life-threatening emergency, call 911. ***Note: Transportation benefits do not apply to FAMIS members**.

If you call after hours, leave a message explaining how to reach you. Your PCP or other provider will call you back as quickly as possible. If you have difficulty getting an appointment with a provider, contact Member Services. Remember to say when you plan to be out of town so Molina can help you arrange your services.

Telehealth

Telehealth lets you get care from your provider without an in-person office visit. Telehealth is usually done online with internet access on your computer, tablet, or smartphone. Sometimes, it can be done over the phone. While telehealth isn't appropriate for every condition or situation, you can often use telehealth to:

- Talk to your provider over the phone or through video chat.
- Send and receive electronic messages with your provider.
- Participate in remote monitoring so that your provider can track how you're doing at home.
- Get medically necessary medical and behavioral health care.

To make a telehealth appointment, contact your provider to see what services they provide through telehealth.

Getting care from the right place when you need it quickly

Choosing the right place to get care based on your health needs is essential, especially when you need care quickly or unexpectedly. Below is a guide to help you decide whether your usual care team, like your PCP, can help you or whether you should go to an urgent care center or the emergency room. If you are unsure what care you need, call your PCP or the Medical Advice Line at (833) 514-1809 24 hours a day, seven days a week. This call is free.

Type of care	How to get care	Examples of when to get this type of care	Need a referral?
Primary Care Physician (PCPs) can provide care for when you get sick or injured and preventive care that keeps you healthy	Contact your office or Molina to schedule an appointment	• Minor illness/injury • Flu/fever • Vomiting/diarrhea • Sore throat, earache, or eye infection • Sprains/strains • Possible broken bones	No
Urgent care is care you get for a sickness or an injury that needs medical care quickly and could turn into an emergency	Check the **provider directory** at MolinaHealthcare.com to find an urgent care clinic	Urgent care can manage similar things as your PCP, but is available when other offices are unavailable	No, but make sure to go to an urgent care clinic that is in network if you can.

Type of care	How to get care	Examples of when to get this type of care	Need a referral?
Emergency care (or care for an emergency medical condition) is care you get when an illness or injury is so serious that your (or, as applicable, your unborn health, bodily functions, body organs or body parts may be in danger if you do not get medical care right away	Call 911 and go to the nearest hospital. You have the right to get emergency care 24 hours a day, seven days a week from any hospital or other setting, even if you are in another city or state. We will provide follow-up care after the emergency	• Unconsciousness • Difficulty breathing • Serious head, neck or back injury • Chest pain/pressure • Severe bleeding • Severe burns • Convulsions/ seizures • Broken bones • Fear you might hurt yourself or someone else ("behavioral health emergency") • Sexual assault	No. You can get emergency care from network providers or out-of-network providers. You do not need a referral or service authorization.

Getting care after hours

If you need non-emergency care after normal business hours, call Molina's Medical Advice Line. A nurse or behavioral health professional can:

- Answer medical questions and give you advice for free.
- Help you decide if you should see a provider right away.
- Help with medical conditions, including cases of severe pain, psychiatric disturbances and/or symptoms of substance abuse in which the absence of immediate medical attention would place the member's health in jeopardy or at risk for serious impairment or bodily dysfunction.

Transportation to care

Non-emergency medical transportation
If you need transportation to receive covered benefits such as medical, behavioral, dental, vision and pharmacy services, call Molina's Transportation Reservation line. Molina covers nonemergency transportation for covered services. If you have trouble getting an appointment, call Molina's Transportation Where's My Ride/Ride Assist, Member Services or your Care Manager. If you have your own ride to your appointment, your driver may be paid back at a set rate per mile (limits apply). Members, family, friends and caregivers are eligible for mileage reimbursement through Molina. You must call (877) 790-9472 or (833) 273-7416 before your appointment to be eligible for reimbursement.

FAMIS children are not eligible for Non-Emergency Medical Transportation.

If you need transportation to developmental disability waiver services, contact the Cardinal Care Transportation for Developmental Disability Waiver Services Contractor at (866) 386-8331 (TTY: 1-866-288-3133) or visit transportation.dmas.virginia.gov/. If you have Problems getting transportation to your developmental disability waiver services, call Where's My Ride at (866) 246-9979 or your developmental disability waiver Case Manager.

Emergency medical transportation

If you are experiencing an emergency medical condition and need transportation to the hospital, call 911 for an ambulance. Molina will cover an ambulance if you need it.

Care Management

Care Management

All members can get help finding the right health care or community resources by calling Molina's Member Services at **(800) 424-4518** (TTY: 711). You can also call **(833) 514-1809** (TTY: 711) 24 hours a day, seven days a week to talk to an on-call nurse or other licensed health professional.

What is Care Management?

If you have significant healthcare needs, you will receive care management. Care management helps to improve the coordination between your different providers and the services you receive. Molina will assign you a care manager if you qualify for care management. Your care manager has particular healthcare expertise and works closely with you, your PCP, treating providers, family members, and others to understand and support your needs and goals.

How to get a Care Manager

During the first three months after you enroll, Molina will contact you or someone you trust (your "authorized representative") to conduct a health screening. During the health screening, you will be asked to answer questions about your health needs (such as medical care) and social needs (such as housing, food, and transportation). The health screening includes questions about your health conditions, ability to do everyday things and living conditions. Your answers will help us understand your needs and decide whether to assign you to a care manager. If you are not assigned a care manager, you can ask Molina to consider giving you one if you need help getting care now or in the future.

If you have questions or need help with the health screening, contact Member Services at **(800) 424-4518** (TTY/TDD: 711). This call is free.

How your Care Manager can help you

Your care manager is someone from Molina with special health care expertise who can help you manage your health and social needs. Your care manager can:

- Assess your health and social needs.
- Answer questions about your benefits, like physical health services, behavioral health services, and long-term services and supports (LTSS). See the *Your Benefits* section for more information.
- Help connect you to community resources (for example, programs that can support your housing and food needs).
- Support you in making informed decisions about your care and what you prefer.

- Assist you with scheduling appointments when needed, find available providers in the Molina network and make referrals to other providers, as needed.
- Help you get transportation to your appointments. See the *Your PCP* section.
- Make sure you get your prescription drugs and help if you feel side effects.
- Share your test results and other health care information with your providers so your care team knows your health status.
- Help with moving between health care settings (like from a hospital or nursing facility to home or another facility).
- Make sure your needs are met once you leave a hospital or nursing facility and on an ongoing basis.

How to contact your Care Manager

Your Care Manager is a healthcare professional who can answer questions about your healthcare, assist with appointment scheduling, help you find providers or necessary services, and help you understand your benefits. If you are assigned a care manager, they will contact you to complete a health risk assessment and develop a plan to help you get the care you need to stay healthy. If you need to request a care coordinator change, you may contact Member Services.

Free interpreter services are available in all languages for people who do not speak English.

Contact method	Contact information
Call	**(800) 424-4518** This call is free. 8 a.m. - 8 p.m. local time, Monday - Friday. We have free interpreter services for people who do not speak English.
Fax	**(855) 472-8574**
Write	3829 Gaskins Road, Richmond VA 23233
Email	**MCCVA@molinahealthcare.com**
Website	**MolinaHealthcare.com**

Your care manager will regularly check in on you and can help with any questions or concerns. You have the right to ask your care manager to contact you more or less often at any time.

You decide how you want your care manager to contact you (by phone, videoconference, or visit you in person). If you meet your care manager in person, you can suggest the time and place. You are encouraged to work with your care manager and openly communicate with them.

Health Risk Assessment

After you complete your health screening, your Care Manager will contact you for a more in-depth health risk assessment. During the health risk assessment, your care manager or another professional will ask you more questions about your physical health, behavioral health, social needs, and goals and preferences.

The health risk assessment helps your care manager understand your needs and provide the proper care. You can do the health risk assessment in person, over the phone, or by video conference. Over time, your care manager will check in to repeat the health risk assessment questions to determine if your needs are changing.

Your Care Plan

Based on your Health Risk Assessment, your care manager will work with you to develop your personalized Care Plan. Your care plan will include the health care, social services, and other supports you will get and explain how you will get them, how often, and by what provider. Your care manager will update your care plan once a year. If your needs shift, your care manager may make changes more often than once a year. It is important to keep your care plan updated.

Your Care Team

Your care team includes your providers, nurses, counselors, or other health professionals. You and your family members or caregivers are important members of your care team. Your care manager may organize a meeting with your care team depending on your needs, or you can ask to meet with your care team. You have a choice of whether to participate in care team meetings. Communication among your care team members helps ensure your needs are met.

Coordination with Medicare or other health plans

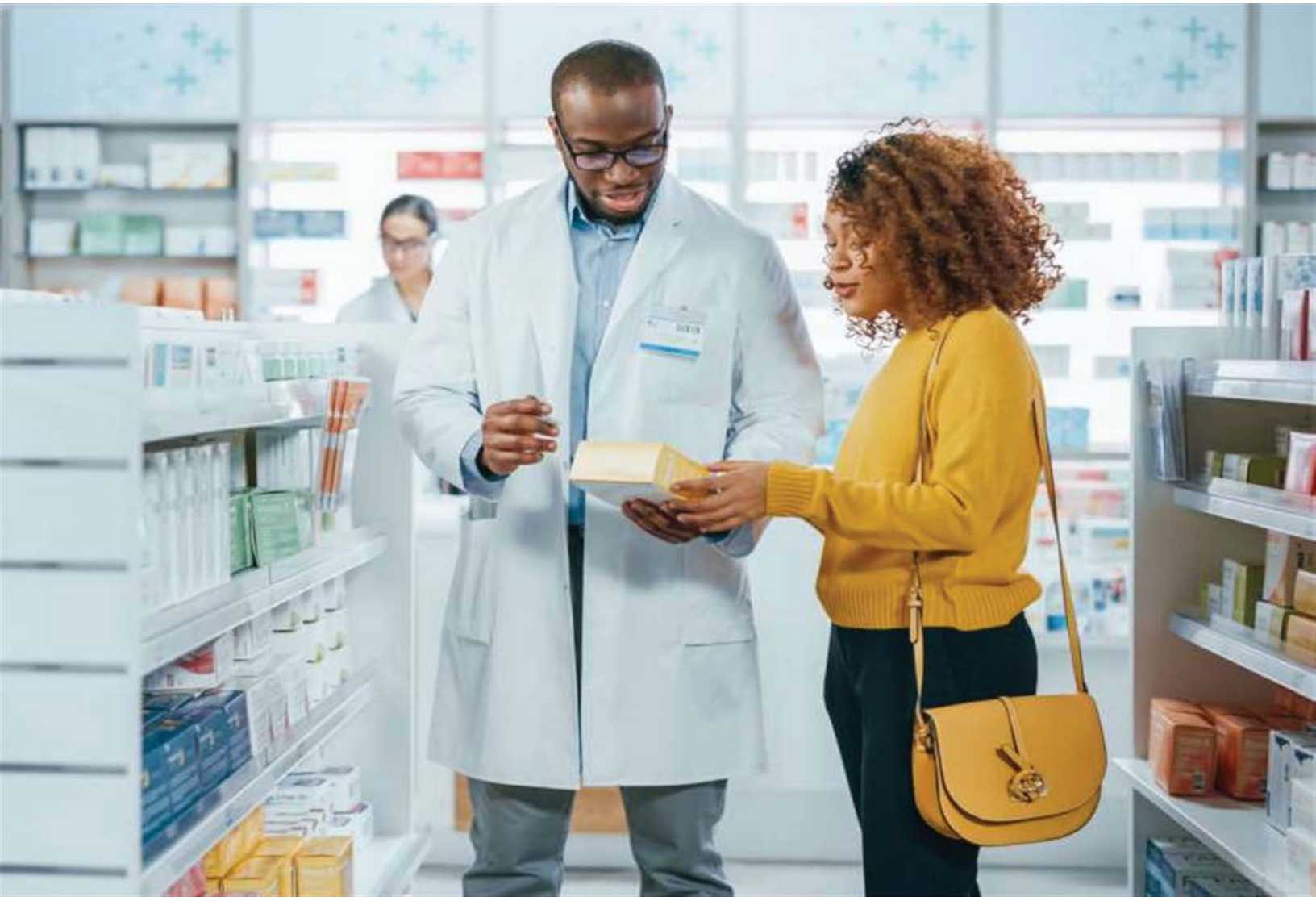
If you have Medicaid and Medicare, Molina is responsible for coordinating your benefits with your Medicare health plan and any other health plan(s) you have. Call Member Services or your care manager if you have questions about how your different health plans work together and make sure your services are paid for correctly.

Additional care management services

You may be able to get additional care management services if you:

- Are or were in foster care.
- Are pregnant and at higher risk for complications during and after pregnancy.
- Receive services in your home or the community, such as home health, personal care, or respite services.
- Have a substance use disorder.
- Use a ventilator.
- Are homeless.

If you need a care manager, call Molina Member Services for assistance at **(800) 424-4518 TTY/ TDD: 711**.



Your Benefits

Overview of covered benefits

Covered benefits are services provided by Molina, DMAS or its contractor. In order to get covered benefits, the service must be medically necessary. A medically necessary service is a service you need to prevent, diagnose, or treat a medical condition or its symptoms.

You can also access the full list of covered benefits at: MolinaHealthcare.com.

Call Member Services at (800) 424-4518 (TTY/TDD: 711) or your Care Manager, if you have one, for more information about your services and how to get them.

Generally, you must get services from a provider that participates in the Molina network. In some cases, you may need to get approval (a "service authorization" from Molina Healthcare or your PCP before getting a service. The services marked in this section with an asterisk (*) require service authorization. See the *Your PCP* section, for more information on what to do if you need services from an out-of-network provider. See the *Getting Approval for your Services, Treatment and Drugs* section for more information if a service you need requires approval.

Benefits for all members

Physical health services

Molina covers physical health services (including dental) for members

Adult day health care (*Waiver eligible members only*)	Hearing services (*children under age 21*)
Cancer screenings and services (colorectal cancer screening, mammograms, pap smears, prostate specific antigen and digital rectal exams, reconstructive breast surgery)	Home and community-based waiver services (more on this below)
Care management and care coordination services (see the *Care Coordination and Care Management* section)	Home health
Clinic services	Hospice
Clinical trials (routine patient costs related to participation in a qualifying trial)	Hospital care (inpatient and outpatient)
Court-ordered services, emergency custody orders (ECO) and temporary detention orders (TDO)	Human Immunodeficiency Virus (HIV) services (testing and treatment counseling)
Dental services (more on this below)	Immunizations (adult and child)
Durable Medical Equipment (DME) (respiratory, oxygen and ventilator equipment and supplies; wheelchairs and accessories; hospital beds; diabetic equipment and supplies; incontinence products; assistive technology; communication devices; rehabilitative equipment and devices)	Laboratory, radiology, and anesthesia services
Early and Periodic Screening Diagnostic and Treatment (EPSDT)* (more on this below)	Lead Investigations
Early Intervention (EI) services (more on this below)	Oral services (hospitalizations, surgeries, services billed by a medical provider)
Emergency and post-stabilization services	Organ transplants (for all children and for adults who are in intensive rehabilitation)
Gender dysphoria treatment services	Orthotics (children under age 21)
Glucose test strips	Nutritional counseling for chronic disease

*** - Not available to FAMIS members**

Long-term Services and Supports (LTSS) Provided in the home or community through a home and community-based (HCBS) waiver	School health services (more on this below)
Podiatry services (foot care)	Surgery services
Prenatal and maternal services (pregnancy/postpartum care) (more on this below)	Telehealth services (more on this below)
Prescription drugs (see the *Your Prescription Drugs* section)	Tobacco cessation services
Preventive care (regular check-ups, screenings and well-baby/child visits)	Transportation services* (see the *Your PCP* section)
Prosthetics (arms/legs and supportive attachments, breasts and eye prostheses)	Tribal clinical provider type services
Regular medical care (PCP office visits, referrals to specialists, exams)	Vision services (eye exams/treatment/glasses to replace those lost, damaged or stolen for children under age 21 (under EPSDT)
Radiology services	Well-visits
Rehabilitation services (inpatient and outpatient, including physical/occupational therapy and speech pathology/audiology services)	
Renal services (dialysis, End Stage Renal Disease services)	

*** - Not available to FAMIS members**

Remember, services marked with an asterisk (*) may require service authorization.

Department contracts with a Dental Benefits Administrator, DentaQuest, to provide dental services to all Medicaid/FAMIS members. See the table below for dental services available to you. You are not responsible for the cost of dental services received from a participating dental provider.

Some dental services will require prior approval. Molina will work with Department's Dental Administrator to authorize some services, including anesthesia when medically necessary. For questions about your dental benefits or to find a participating dentist near you, call DentaQuest Member Services at **(888) 912-3456 (TTY/TDD: (800) 466-7566)** or visit **Dmas.virginia.gov/dental**.

Dental service	Children/youth under age 21	Pregnant/ postpartum people	Adults 21 and over
Braces	Covered	Not covered	Not covered
Cleanings	Covered (including fluoride)	Covered	Covered
Crowns	Covered	Covered	Limited coverage
Dentures	Covered (including partials)	Covered (including partials)	Covered
Exams	Covered (including regular check-ups)	Covered	Covered
Extractions and oral surgents	Covered	Covered	Covered
Fillings	Covered	Covered	Covered
Gum treatment	Covered	Covered	Covered
Root canals	Covered (including treatment)	Covered	Covered
Sealants	Covered	Not covered	Not covered
Space maintenance	Covered	Not covered	Not covered
X-Rays	Covered	Covered	Covered

Behavior health services

Molina, DMAS or its contractor covers the behavioral health treatment services in the table below for members. Behavioral health refers to mental health and addiction services. In Virginia, treatment for addiction is called "Addiction and Recovery Treatment Service" (ARTS). Call Member Services, your PCP, or your care manager for help getting the behavioral health services you need.

Mental health services	Addition and Recovery Treatment Services
• 23-hour observation • Applied behavior analysis • Assertive community treatment • Community stabilization • Functional family therapy • Intensive in-home • Mental health case management • Mental health intensive outpatient • Mental health partial hospitalization program • Mental health peer recovery supports services • Mental health skill-building services • Mobile crisis • Multisystemic therapy • Psychiatric residential treatment facility • Psychosocial rehabilitation • Residential crisis stabilization • Therapeutic day treatment • Therapeutic group home • Inpatient psychiatric services • Outpatient psychiatric services	• Screening, brief intervention and referral to treatment • Substance use case management services • Outpatient services • Intensive outpatient services • Partial hospitalization • Substance use residential treatment • ASAM 3.1** • ASAM 3.3** • ASAM 3.5** • ASAM 4.0** • Medication Assisted Treatment • Peer Recovery Support Services • Opioid Treatment Services • Office Based Addiction Treatment

* Services that are managed by the Department's behavioral health administrator contractor. Your care manager will work with the Department's behavioral health administrator contractor to help you get these services if needed.

For questions about addiction and recovery services, call or text 988 or chat the ARTS Medical Advice Line at **https://988lifeline.org/**.

If you are thinking of harming yourself or someone else, call the Behavioral Health Crisis Line at **(833) 514-1809** (TTY/TDD: 711) 24 hours a day, seven days a week. This call is free. Remember, if you need help right away, call **911**!

**American Society of Addiction Medicine (ASAM) – Levels of Care

Below is a list of the different levels of care for addic on treatment

ASAM 3.1 (American Society of Addiction Medicine Level 3.1) is a Clinical Managed Low-Intensity Residential Treatment Program for Substance Use Disorders. The ASAM 3.1 level of care provides a structured setting that is safe with a stable environment where members can practice coping skills and self-efficacy and connect with the community to develop skills and prepare for a less intensive level of treatment.

ASAM 3.3 (American Society of Addiction Medicine Level 3.3) is a Clinically Managed Medium-Intensity Residential Treatment Program for Substance Use Disorders. This program has an interdisciplinary team that provides treatment for individuals who move at a slower pace, for members with cognitive functional issues, traumatic brain injuries, the elderly, or members with developmental disabilities.

ASAM 3.5 (American Society of Addiction Medicine Level 3.5) is a clinically managed residential service that provides 24-hour clinical support for members with an addiction who have serious psychological or social issues. This level of care is for members who are unable to make progress with their addiction and are at risk of imminent harm.

ASAM 4.0 (American Society of Addiction Medicine Level 4.0) is a Medically Managed Intensive Inpatient Service. This level of care is for members with severe biomedical, emotional, behavioral, or cognitive problems that require primary medical and nursing care. This is the highest level of service with high-level medical monitoring and daily physician visits. This service can include an acute withdrawal that is life-threatening with medical complications.

Long-Term Services and Supports (LTSS)

Molina and DSS cover LTSS benefits such as private-duty nursing, personal care, and adult day health care services to help you meet your daily needs and maintain your independence while living in the community or a facility. Before receiving LTSS benefits, a community-based or hospital team will screen to see if you meet "level of care" criteria - in other words, whether you qualify for and need LTSS benefits. Contact your care manager to learn about the screening process to receive LTSS benefits.

You can get LTSS benefits in the right setting for you: your home, the community, or a nursing facility. Members interested in moving from the nursing facility into their home.

or the community should talk with their care manager. However, it is essential to know that receiving certain types of care will end your enrollment with managed care and Molina, but you will still have Medicaid. These types of care include:

- Intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- Care from one of the following nursing facilities:
  - Bedford County Nursing Home
  - Birmingham Green
  - Dogwood Village of Orange County Health
  - Lake Taylor Transitional Care Hospital
  - Lucy Corr Nursing Home
  - The Virginia Home Nursing Facility
  - Virginia Veterans Care Center
  - Sitter and Barfoot Veterans Care Center
  - Braintree Manor Nursing Facility and Rehabilitation Center
- Care from Piedmont, Hiram Davis or Hancock state-operated long-term care facility.
- Program of All Inclusive Care for the Elderly (PACE) care.

If you get LTSS benefits, you may need to pay for part of your care. See the *Cost sharing* section for more information. If you have Medicare, Molina will cover nursing facility care after you have used all of the skilled nursing care that was available to you.

Benefits for Home and Community Based Services (HCBS) waiver enrollees

Some members may qualify for HCBS waiver services (see table below). To learn more or to find out if you are eligible, contact Member Services or your care manager. Developmental disability waiver services are managed through the Department of Behavioral Health and Developmental Services (DBHDS). You can also find more information about developmental disability waiver services on the DBHDS website: **Mylifemycommunityvirginia.org** or by calling **(844) 603-9248**.

Waiver	Description	Examples of covered benefits
Commonwealth Coordinated Care (CCC) Plus Waiver	Provides care in your home and community instead of a nursing facility. You can choose to receive agency-directed or consumer-directed services, or both.	• Adult day health care • Assistive technology • Environmental modifications • Personal care • Personal Emergency Response System • Private duty nursing • Respite • Transition services
Developmental Disability Waivers: Building Independence (BI) Community Living (CL) Family and Individual Supports (FIS)	Provides supports and services to members with developmental disabilities to help with successful living, learning, physical and behavioral health, employment, recreation and community inclusion. Waivers may have a waiting list. You should put your name on the waiting list if you need to so that when space opens up you can start receiving these services.	• Assistive technology • Benefits planning services • Electronic home-based services • Employment and day supports • Environmental modifications • Personal emergency response system • Crisis supports • Residential options

Benefits for children/youth under age 21

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

Benefits are not the same for all Molina members. Children and youth under age 21 who Medicaid covers are entitled to EPSDT, a federally required benefit. EPSDT provides comprehensive services to identify a child's condition, treat it, and improve it or prevent it from worsening. Covered services include any medically necessary health care, even if the service is not usually available to adults or other Medicaid members. EPSDT services are available at no cost. Examples of EPSDT services include:

- Screenings/well-child visits and immunizations
- Periodic screening services (vision, hearing and dental)
- COVID-19 counseling visits
- Developmental services
- Eyeglasses (including a replacement for glasses that are lost, broken, or stolen) and other vision services
- Orthotics (braces, splits, supports)
- Personal care or personal assistance services (help with bathing, dressing, feeding, for ex-ample)
- Private duty nursing
- Treatment foster care case management
- Clinical trials may be considered on a case-by-case basis

FAMIS children are eligible for well-child visits and immunizations, but not all EPSDT services. For more information on accessing EPSDT services, contact Molina Member Services or your care manager. Additional information and training regarding Molina's EPSDT program are available **here**:

Early Intervention (EI) Services

If you have a baby under the age of three that is not learning or developing like other babies, your child may qualify for EI services. EI services include:

- Speech therapy.
- Physical therapy.
- Occupational therapy.
- Service coordination.
- Developmental services to support the child's learning and development.

EI services do not require service authorization from Molina. There is no cost to you for EI services. Contact Member Services for a list of EI providers, specialists, and case managers. Your care manager can connect you to your local Infant and Toddler Connection program to help you access these services. You can also call the Infant and Toddler Connection program directly at **(800) 234-1448**. (TTY/TDD: 711) or visit **Itcva.online**.

School health services

DMAS covers the cost of some health care or health-related services provided to Molina-enrolled children at their school. School health services can include certain medical, behavioral health, hearing, personal care, or rehabilitation therapy services, such as occupational therapy, speech therapy, and physical therapy services, and are based on your child's individualized education plan (IEP), as determined by the school. Your child's school will arrange for these free services. Children may also receive covered EPSDT services at school (see the *Your Benefits* section). Contact your child's school administrator if you have questions about school health services

Benefits for family planning and pregnant/postpartum people

You can get free health care services to help you have a healthy pregnancy and a healthy baby. This includes health care services for up to 12 months after you give birth. Molina and DMAS cover the following services:

- Care Management (High-risk conditions)
- Labor and delivery services
- Doula services
- Family planning (services, devices, drugs including long-acting reversible contraception and supplies for the delay or prevention of pregnancy)
- Lactation consultation and breast pumps
- Nurse midwife/provider services
- Pregnancy-related services
- Prenatal/infant services and programs
- Postpartum services (including postpartum depression screening)
- Services to treat any medical condition that could complicate pregnancy
- Smoking cessation services
- Substance use treatment services
- Abortion services (if there is a substantial danger to the mother's life

Remember, you do not need a service authorization or a referral for family planning services. You can get family planning services from any provider, even if they are not in the Molina network.

Newborn coverage

If you have a baby, report the birth to the Department as quickly as possible so that your child can get health insurance. Do this by calling **Cover Virginia** at **(833) 5-CALLVA** or by contacting your **local DSS**.

Added benefits for Molina Healthcare members

Molina provides some added benefits for members. These include:

Benefit	Details
Vision	Up to $100 for glasses or contacts every two years for adults 21 and over
Mother-Baby Connections	Text messages with important health information to help: • Understand what is happening with your body. • Recognize warning signs. • Know what to expect during your delivery You'll also get: • Infant sleep sacks and diapers • An invitation to baby showers hosted by Molina (quarterly per region) • "Baby Basics" book • Rides to WIC appointments, Lamaze and parenting classes
Sports physicals	Annual sports physicals from a primary care physician (PCP) for children ages 10-18
Adult physicals	Routine physicals from a PCP for adults 21 and over
Bicycle helmets	One bicycle helmet per year for children under 18
Transitions of Care for Foster Children	Backpack with supplies (personal hygiene items, community resource guides, area maps) for foster children leaving foster care

Your Prescription Drugs

Understanding your prescription drug coverage

Connect to our secure portal from any device, wherever you are. Change your doctor and update your Prescription drugs and medicines your provider orders ("Prescribes") for you. Usually, Molina will cover ("pay for") your medications if your PCP or another provider writes you a prescription and your prescription is on the Preferred Drug List. If you are new to Molina, you can keep getting the drugs you are already taking for up to 30 days (or less if the drugs are authorized for fewer than 30 days). If you are pregnant or have high health or social needs, you can keep getting the medications you are already taking for up to 60 days (or less if the drugs are authorized for fewer than 60 days). If a prescription you need is not on the Preferred Drug List, you can still get it if it is medically necessary.

To know which prescriptions are covered by Molina and the Department, see the Preferred Drug List at **MolinaHealthcare.com.** The Preferred Drug List can change during the year, but Molina will always have the most up-to-date information.

You can access or download the provider and pharmacy directory at **MolinaHealthcare.com** or receive a printed copy by calling **(800) 424-4518** (TTY/TDD: 711). A preferred drug list is a list of drugs the Plan covers that are safe and helpful for receiving quality care. We will generally cover the drugs in our preferred drug list as long as the medication is medically necessary, the drug is filled at a participating pharmacy, and other Plan rules are followed. For more information on how to fill your prescriptions and details on quantity limits, prior approval requirements, and age limits, please visit **MolinaHealthcare.com**.

By law, some drugs cannot be covered, including experimental drugs, drugs for weight loss or weight gain, medications used to promote fertility or for the treatment of sexual or erectile dysfunction, and drugs used for cosmetic purposes.

Prescription drugs for FAMIS members
Generic outpatient prescription drugs are covered. If you choose a brand-name drug, you are responsible for 100% of the difference between the allowable charge of the generic drug and the brand-name drug.

Understanding medications with special rules and restrictions
Some drugs have rules or restrictions on them that limit how and when you can get them. For example, a medicine may have a quantity limit, which means you can only get a certain amount of the drug each time you fill your prescription. For medications with special rules, you may need a service authorization from Molina before filling your prescription. See the *Getting Approval for your Services, Treatments and Drugs* section. Molina may not cover the drug if you do not get approval.

To determine if the drug you need has a special rule, check the Preferred Drug List. If Molina denies or limits your coverage for a drug and you disagree with the decision, you have the right to appeal (see the *Appeals and Complaints* section).

In some cases, Molina may require "step therapy" This is when you try a drug (usually one that is less expensive) before Molina will cover another drug (usually one that is more expensive) for your medical condition. If the first drug does not work, then you can try the second drug.

Emergency supply of drugs
If you ever need a drug and you cannot get a service authorization quickly enough (like over the weekend or a holiday), you can get a short-term 72-hour supply of your drug if a pharmacist believes that your health would be at risk without the benefit of the drug. When this happens, the pharmacists may enter an override code or prior authorization number (i.e., 11112222333) and a PA Type Code (i.e., 8) to authorize a 72-hour emergency supply.

Long-term supply of drugs
Virginia Medicaid requires Molina Healthcare provide coverage of a maximum 90-day supply of many maintenance drugs. The list of eligible maintenance drugs includes many highly utilized medications on the Molina Preferred Drug List, which members typically receive for long-term therapy. Members will be eligible for this policy after receiving two 34-day or shorter fills of drugs on this list. To see what medications are included in the 90 Day Supply List, please review the list **here** or on **MolinaHealthcare.com**. If a medication is not on the maintenance list, you may receive a maximum 34-day supply of your prescriptions.

Getting your drugs from a network pharmacy

Once your provider orders a prescription for you, you will need to get your prescription drugs filled at a network pharmacy (except during an emergency). A network pharmacy is a drug store that agrees to fill drugs for Molina members. To find a network pharmacy, use your provider directory available **here**. You can use any Molina network pharmacy.

If you need to change pharmacies, you can ask your pharmacy to transfer your prescription to another network pharmacy. If your pharmacy leaves the Molina network, you can find a new pharmacy in the provider directory or by calling Member Services at **(800) 424-4518** (TTY/TDD: 711)**.**

When you go to the network pharmacy to drop off a prescription or pick up your drugs, show them your Molina Member ID Card. If you have Medicare, show both your Medicare Card and Molina member ID card. Call Member Services or your care manager if you have questions or need help getting a prescription filled or finding a network pharmacy.

Getting your drugs mailed to your home

Sometimes, you may need a drug that is not available at a pharmacy near you, such as a drug used to treat a complex condition or one that requires special handling and care. If this happens, a specialized pharmacy will ship these drugs to your home or your provider's office.

Molina uses CVS Caremark Mail Service Pharmacy to deliver 90-day supplies of medications you take regularly to your door. This benefit is permitted for medications included on the DMAS 90-day drug list. Please call CVS Caremark Mail Service Pharmacy at **(844) 285-8668** (TTY/TDD: 711) to start using this service. Additional information may be accessed at **Caremark.com**.

Patient utilization management and safety program

Some members who need additional support with their medication management may be enrolled in the Patient Utilization Management and Safety Program. The program helps coordinate your drugs and services so that they work together in a way that will not harm your health. Members in the Patient Utilization Management and Safety Program may be restricted (or locked in) to only using one pharmacy to get their drugs.

Molina will send you a letter with more information if you are in the Patient Utilization Management and Safety Program. If you are placed in the program but do not think you should have been, you can appeal within 60 days of receiving the letter (see the *Appeals and Complaints* section).

Specialty pharmacy program

Sometimes, you may need a drug that is not available at a pharmacy near you, such as a drug used to treat a complex condition or one that requires special handling and care.

These specialty medicines can be oral, but many times, they are injected, infused, or inhaled medicines. If this happens, a specialized pharmacy will ship these drugs to your home or your provider's office. These may need special storage or handing. CVS Specialty Pharmacy is our preferred specialty pharmacy. We'd like you to get your specialty medicine sent through the mail from CVS Specialty Pharmacy. CVS Specialty Pharmacy will work closely with you and your provider to give you what you need to help manage your condition.

Prescription drug requests for specialty medications for Molina members need to be submitted to CVS Specialty Pharmacy for fulfillment. Please call CVS Specialty Pharmacy at

(800) 237-2767 (TTY/TDD: 711). They're available Monday through Friday from 8 a.m. to 10 p.m. local time. The pharmacy is available 24 hours a day, seven days a week for emergencies.

Have questions? Please call CVS Specialty Pharmacy at **(800) 237-2767** (TTY/TDD 711). They're available Monday through Friday from 8 a.m. to 10 p.m. local time. The pharmacy is available 24 hours a day, seven days a week for emergencies.

Over-the-counter medications

Molina pays for over-the-counter (OTC) medications included in the Virginia Medicaid Preferred Drug or the Commonwealth's Pharmacy Manual of Covered Services. Molina also provides an enhanced OTC benefit of up to $50 per quarter for OTC medications not included in the Virginia Medicaid Preferred Drugs or the Commonwealth's Pharmacy Manual of Covered Services. To get an OTC Medication on Molina's List of Covered Drugs, you need to get a prescription from your doctor first. Take the prescription to a pharmacy in the Molina network or have your doctor call it in.

Pharmacy service authorizations

Some drugs have rules or restrictions on them that limit how and when you can get them. For example, a medicine may have a quantity limit, which means you can only get a certain amount of the drug each time you fill your prescription. For medications with special rules, you may need a service authorization from Molina before filling your prescription (see the *Getting Approval for your Services, Treatments, and Drugs* section). Molina may not cover the drug if you do not get approval. Remember, medications marked with "PA" in the Requirements/Limits column in the Preferred Drug List require service authorization. In some cases, Molina may require "step therapy". This is when you try a drug (usually one that is less expensive) before Molina will cover another drug (usually one that is more expensive) for your medical condition. If the first drug does not work, then you can try the second drug.

If Molina denies or limits your coverage for a drug and you disagree with the decision, you have the right to appeal (see the *Appeals and Complaints* section).

Getting Approval for your Services, Treatments, and Drugs

If you disagree with your provider's opinion about the services you need, you have the right to a second opinion. You can get a free second opinion from a network provider without a referral. When network providers are not accessible or when they cannot meet your needs, Molina can refer you to an out-of-network provider for a second opinion at no cost.

Service authorization

There are some services, treatments and drugs you may need to obtain approval. This is known as a service authorization. Your doctor will be responsible for making requests. A service authorization helps to figure out if certain services are medically necessary and if Molina can cover them for you. After assessing your needs and making a care

recommendation, your provider must submit a request for a service authorization to Molina with information that explains why you need the service. This helps make sure that they can be paid for the services they provide to you.

If you are new to Molina, we will honor any service authorizations made by the Department or another health plan for up to 60 days (or until the authorization ends if that is sooner). This 60-day period also applies to pregnant members or those who have significant health or social needs.

Decisions are based on what is right for each member and on the type of care and services that are needed. We look at standards of care based on: Medical policies National clinical guidelines Medicaid guidelines and health benefits

Molina does not reward employees, consultants, or other providers to: Deny care or services that you need Support decisions that approve less than what you need Say you do not have coverage

You can request your doctor's incentive plans. See the *Your Benefits* Section for the specific services that require service authorization.

Service authorization is never required for primary care services, emergency care, preventive services, EI services, family planning services, basic prenatal care, or Medicare-covered services.

How to get a service authorization

If the services you require are covered through Medicare then a service authorization from Molina is not required. If you have questions regarding what services are covered under Medicare, please contact your Medicare health plan. You can also contact your Care Manager.

Decisions are based on what is right for each member and on the type of care and services that are needed. We look at standards of care based on:

We look at standards of care based on:

- Medical Policies
- National clinical guidelines
- Medicaid guidelines
- Your health benefits

Molina does not reward employees, consultants, or other providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you don't have coverage

Service authorizations are not required for early intervention services, emergency care, family planning services (including long-acting reversible contraceptives), preventive services or basic prenatal care.

To find out more about how to request approval for services or to obtain an authorization you can contact Member Services at **(800) 424-4518** (TTY/TDD: 711). Member Services or your Care Manager can help answer your questions and share more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your Care Manager can help you find the right provider who can help figure out if you need the service.

Timeframe for service authorization review

After receiving your service authorization request, Molina will make a decision on whether to approve or deny a request. Normally, Molina will give written notice as quickly as needed, and within 14 calendar days. If waiting that long could seriously harm your health or ability to function, we will decide more quickly and instead give written notice within three calendar days.

Molina will make any decisions about pharmacy services within 24 hours. On weekends or holidays, we may authorize a 72-hour emergency supply of your prescribed drugs. This gives your provider time to submit a service authorization request and for you to potentially receive an additional supply of your prescribed drug after the 72-hour emergency supply is done.

Molina will contact your provider if we need more information or time to make a decision about your service authorization. You will be informed of the communication to your requesting provider. If you disagree with Molina taking more time to review your request or if you do not like the way we handled your request, see the, *Appeals and Complaints* section, on how to file a complaint. You can talk to your Care Manager about your concerns, or you may call the Managed Care Enrollment Helpline at **(800) 643-2273** (TTY/TDD: **(800) 817-6608)**. If you have more information to share with Molina that would help decide your case, then you, someone you trust or your provider can ask Molina to take more time to make a decision in order to include the additional information.

Adverse benefit determinations

If Molina denies a service authorization request, this is called an adverse benefit determination. An adverse benefit determination can also occur when Molina approves only part of the care request or a service amount that is less than what your provider requested. Examples of adverse benefit determinations include when Molina:

- Denies or limits a request for health care or other services you or your provider think you should get including services outside of your provider's network.
- Reduces, pauses or stops health care or other services you were already receiving.
- Fails to provide services in a timely manner.
- Fails to act in a timely manner to address grievances and appeals.
- Denies your request to reconsider a financial liability.
- Does not pay for all or part of your health care or services.

If Molina makes an adverse benefit determination, Molina will usually notify you and your provider in writing at least 10 days before making changes to your service. But, if you do not hear from Molina, you should assume that your service authorization request was denied.

When Molina tells you about the decision in writing, we will tell you what the decision was, why the decision was made, and how to appeal if you disagree. You should share a copy of the decision with your provider. If you disagree with the decision, you can re- quest an appeal.

See the *Appeals and Complaints* section, for more information on the appeal process.

Call Member Services at (800) 424-4518 (TTY/TDD: 711) to let them know if:

- Your name, address, phone number or email have changed (see the *Welcome* section).
- Your health insurance changes in any way from your employer or workers' compensation for example) or you have liability claims, like from a car accident.
- Your member ID card is damaged, lost, or stolen.
- You have problems with health care providers or staff.
- You are admitted to a nursing facility or the hospital.
- Your caregiver or anyone responsible for your changes.
- You join a clinical trial or research study.

Appeals and Complaints

Appeals

When to file an appeal with Molina Healthcare
You have the right to file an appeal if you disagree with an adverse benefit determination, (see the *Getting Approval for your Services, Treatments, and Drugs* section), that Molina makes about your health coverage or covered services. You (or someone you trust) must appeal within 60 calendar days after learning about the service authorization request decision. If you choose to let someone you trust file the appeal on your behalf, you must call Member Services at **(800) 424-4518** (TTY/TDD: 711) and let Molina know. See the *Getting Approval for your Service, Treatments and Drugs* section, for more information on service authorizations and adverse benefit determinations. If you need assistance with an appeal, you may talk to your care manager.

You will not lose coverage if you file an appeal. In some cases, you may be able to keep getting services that were denied while you wait for a decision on your appeal. Contact Member Services if your appeal is about a service that is scheduled to end or be reduced. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

How to submit your appeal to Molina Healthcare

You can file your appeal by phone or in writing. You can submit either a standard (regular) or an expedited (fast) appeal request. You might decide to submit an expedited appeal if you or your provider believe your health condition or need for the services requires urgent review.

Phone Requests	**(800) 424-4518** TTY/TDD: 711
Written Requests	Mail to: Appeals & Grievances Molina Healthcare, Inc. PO Box 36030 Louisville, KY 40233-6030
Fax Requests	**(866) 325-9157**

Timeframe for appeal to Molina Healthcare
When you file an appeal, be sure to let Molina know of any new or additional information that you want us to use in making the appeal decision. You can also call Member Services if you need help. Molina will send you a letter to let you know that we received your appeal.

If we need more information to help make an appeal decision, we will send you a written notice within two calendar days of receiving your appeal to tell you what information is needed. For expedited appeals (meaning appeals that need to happen on a faster than normal timeline), Molina will also call you right away. If we need more information, the decision about your standard or expedited appeal could be delayed by up to 14 days from the respective timeframes.

If Molina has all the information needed from you:

- Within 72 hours of receiving your expedited appeal request, we will send you a written notice and try to provide you with a verbal notice about the decision.
- Within 30 days of receiving your standard appeal request, Molina will send you a written notice about the decision.

If you are unhappy with Molina's appeal decision

You can file an appeal with DMAS through what is called the State Fair Hearing process after filing an appeal with Molina if:

- You disagree with the final appeal decision you receive from Molina **OR**
- Molina does not respond to your appeal in a timely manner.

Like the Molina appeals process, you may be able to keep getting services that were denied while you wait for a decision on your State Fair Hearing appeal (but may ultimately have to pay for these services if your State Fair Hearing appeal is denied).

How to submit your state fair hearing appeal

You (or your authorized representative) must appeal to the state within 120 calendar days from when Molina issues its final appeal decision. You can appeal by phone, in writing, or electronically. If you appeal in writing, you can write your own letter or use the Department's appeal request form. Be sure to include a full copy of the final written notice showing the Molina appeal decision and any documents you want DMAS to review. If you have chosen an authorized representative, you must provide documents that show that individual can act on your behalf.

If you want your State Fair Hearing to be handled quickly, you must clearly state "EXPEDITED REQUEST" on your State Fair Hearing request. You must also ask your provider to send a letter to the Department that explains why you need an expedited State Fair Hearing request.

Phone Requests	(804) 371-8488 TTY: (800) 828-1120
Written Requests	Department of Medical Assistance Services Appeals Division 600 E. Broad Street Richmond, VA 23219 Fax: (804) 452-5454
Electronic requests	Website: Dmas.virginia.gov/appeals Email: appeals@dmas.virginia.gov

How to file the State Fair Hearing request

You or your representative, acting on your behalf, can file the appeal request any of the following ways:

1. **Electronically.** Online at **dmas.virgina.gov/appeal** or email to **appeals@dmas.virginia.gov**.
2. **Fax.** Fax your appeal request to DMAS at **(804) 452-5454**.
3. **Mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.
4. **Telephone.** Call DMAS at **(804) 371-8488** (TTY/TDD: **(800) 828-1120**).

To help you prepare your appeal, an appeal request form is available from DMAS at **dmas.virginia.gov/appeals** or by calling **(804) 371-8488**. You can also write your own letter.

Timeframe for State Fair Hearing appeal

After you file your State Fair Hearing appeal, DMAS will tell you the date, time, and location of the scheduled hearing. Most hearings can be done by phone. You may also request an in-person hearing.

If you qualify for an expedited State Fair Hearing appeal, the hearing will usually take place within one to two days of DMAS receiving the expedited request letter from your provider. DMAS will issue a written appeal decision within 72 hours of receiving the expedited request letter from your provider.

For standard State Fair Hearing appeals, DMAS will usually issue a written appeal decision within 90 days of you filing your appeal. The 90-day timeframe does not include the number of days between the Molina decision on your appeal and the date you sent your State Fair Hearing request to the Department. You will have the chance to participate in a hearing and present your position.

State Fair Hearing outcome

If the State Fair Hearing reverses Molina's appeal decision, we must authorize or provide the services as quickly as your condition requires and no later than 72 hours from the date the Department gives us notice. If you continued to get services while you waited for a decision on your State Fair Hearing appeal, Molina must pay for those services. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed. The State Fair Hearing decision is the Department's final decision. If you disagree, you may appeal to your local circuit court.

How FAMIS members ask for an External Review

FAMIS members can request an external review instead of a State Fair Hearing. You or your authorized representative must submit a written request for external review within 30 calendar days of receipt of the Molina final appeal decision. Please mail external review requests to:

FAMIS External Review
c/o Kepro 2810 N. Parham Road Suite 305
Henrico, VA 23294

Or submit online at www.DMAS.KEPRO.COM

Please include: your name, your child's name and ID number, your phone number with area code, and copies of any relevant notices or information.

Complaints

When to file a complaint

You have the right to file a complaint (a "grievance") at any time. You will not lose your coverage for filing a complaint.

You can complain about anything except a decision about your health coverage or covered services. (For those types of issues, you will need to submit an appeal - see above). You can file a complaint with either Molina or an outside organization if you are unhappy. You can make complaints about:

- Accessibility: for example, if you cannot physically access your you need language assistance and did not get it.
- Quality: for example, if you are unhappy with the quality of care you got in the hospital.
- Customer services: for example, if your provider or health care staff was rude to you.
- Wait times: for example, if you have trouble getting an appointment or have to wait a long time to see your provider.
- Privacy: for example, if someone did not respect your right to privacy or shared your confidential information.

How to file a complaint with Molina

To file a complaint with Molina or to inform Molina of your choice to let someone you trust file a complaint on your behalf, please call Member Services at **(800) 424-4518** (TTY/TDD: 711). If you choose to have an authorized representative or someone you trust file the complaint on your behalf, Molina requires written consent from you, the member. If you have any questions, do not hesitate to contact Member Services.

Appeals and Grievances
Molina HealthCare, Inc.
PO Box 36030
Louisville, KY 40233-6030

Be sure to include details on what the complaint is about so that we can help you as best we can.

Molina will tell you about our decision within 90 calendar days after getting your complaint. If your complaint is about your request for an expedited appeal (see above), we will respond within 24 hours of getting your complaint.

How to file a complaint with an outside organization

To file a complaint with an outside organization that is not affiliated with Molina , you can:

- Call the Cardinal Care Managed Care Enrollment Helpline at **(800) 643-2273** (TTY/TDD: **(800) 817-6608**).
- Contact the U.S. Department of Health and Human Services' **Office for Civil Rights**:
  - **Phone Requests: (800) 368-1019** (TTY/TDD: **(800) 537-7697)**.
  - **Written Requests:** Office of Civil Rights - Region III, Department of Health and Human Services, 150 S Independence Mall West Suite 372, Public Ledger Building, Philadelphia, PA 19106; or fax to **215-861-4431**.
- Contact the Virginia Long-Term Care Ombudsman (for complaints or concerns about transitions from a nursing facility or assisted living facility to the community, involuntary transfers or discharges, or unsafe discharge planning made on your behalf):
  - **Phone Requests: (800) 552-5019** (TTY/TDD: **(800) 464-9950)**.
  - **Written Requests:** Virginia Office of the State Long-Term Care Ombudsman, Virginia Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive Henrico, Virginia 23229.
- Contact the Office of Licensure and Certification at the Virginia Department of Health (for complaints specific to nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans):
  - **Phone Requests: (800) 955-1819** (TTY/TDD: 711)
  - **Written Requests:** Virginia Department of Health, Office of Licensure and Certification, 9960 Maryland Drive, Suite 401, Richmond, Virginia 23233-1463; or email:
  - **mchip@vdh.virginia.gov**.

Cost-Sharing

Copayments

Copayments are when you pay a fixed amount for certain services covered by Molina or DMAS. Most members will not owe copayments for covered services. However, there are some exceptions (see below). If you receive a bill for a covered service, contact Member Services for help at (800) 424-4518 (TTY/TDD: 711). Remember, if you get services that are not covered through Molina or DMAS, you must pay the full cost yourself.

If you have Medicare, you may have copayments for prescription drugs covered under Medicare Part D.

Patient Pay

If you get LTSS, you may need to pay for part of your care. This is called your patient pay amount. If you have Medicare, you may also have a patient pay responsibility towards skilled nursing facility care. Your local DSS will notify you if you have a patient pay responsibility and can answer questions about your patient pay amount.

Premiums

You do not need to pay a premium for your coverage. However, DMAS pays Molina a monthly premium for your coverage. If you are enrolled in Molina but do not actually qualify for coverage because information you provided to DMAS or Molina was false or because you did not report a change (like an increase in your income, which may impact whether you qualify for Medicaid/FAMIS), you may have to pay DMAS back the cost of the monthly premiums. You will have to pay DMAS even if you did not get services during those months.

Your Rights

General Rights

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

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability.
- Be treated with respect and consideration for your privacy and dignity.
- Get information (including through this handbook) about your health plan, provider, coverage, and benefits.
- Get information in a way you can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access health care and services in a timely, coordinated, and culturally competent way.
- Get information from your provider and health plan about treatment choices.
- Participate in all decisions about your health care, including the right to say "no" to any treatment offered.
- Ask your health plan for help if your provider does not offer a service because of moral or religious reasons.
- Get a copy of your medical records and ask that they be changed or corrected in accordance with State and Federal Law..
- Have your medical records and treatment be confidential and private. Molina Healthcare will only release your information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse.
- Live safely in the setting of your choice. If you or someone you know is being abused, neglected, or financially taken advantage of, call your local DSS or Virginia DSS at (888) 832-3858. This call is free.)
- Receive information on your rights and responsibilities and exercise your rights without being treated poorly by your providers, Molina, or DMAS.
- Exercise your rights without being treated poorly by your providers, Molina Healthcare, or DMAS.
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- File appeals and complaints and ask for a State Fair Hearing (see the *Appeals and Complaints* section).
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).

Advance Directives

Advance directives are written instructions to those caring for you that tell them what to do if you are unable to make health care decisions for yourself. Your advance directive lists the type of care you do or do not want if you become so ill or injured that you cannot speak for yourself. It is your right and choice about whether to fill out an advance directive. Molina Healthcare is responsible for providing you with written information about advance directives and your right to create an advance directive under Virginia law. Molina Healthcare must also help you understand why Molina Healthcare may not be able to follow your advance directive.

If you want an advance directive, you can fill out an advance directive form. You can get an advance directive form from:

- Virginiaadvancedirectives.org.
- Your care manager, if you have one.
- Your provider, a lawyer, a legal services agency, a social worker, the hospital.
- Molina Healthcare Member Services, if applicable.

You can cancel or change your advance directive or power of attorney if your decisions or preferences about your health care decisions or authorized representative change. If your provider is not following your advance directive, complaints can be filed with the Enforcement Division at the Virginia Department of Health Professions:

- **Phone: (800) 533-1560** (TTY/TDD: 711).
- **Email: enfcomplaints@dhp.virginia.gov.**
- **Write:** Virginia Department of Health Professions, Enforcement Division, 9960 Maryland Drive, Suite 300, Henrico, Virginia 23233-146.

If you believe Molina Healthcare has not provided you with the information you need about advance directives, or you are concerned that Molina Healthcare is not following your advance directive, you can contact DMAS to file a complaint:

- **Call: (800) 643-2273** (TTY/TDD: 711)
- **Email: DMAS-Info@dmas.virginia.gov,** or
- **Write:** Department at Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

Member Advisory Committee

You have the right to let us know how DMAS and Molina can better serve you. You can do this by joining the Member Advisory Committee. As a member of the committee, you can participate in educational meetings that happen once every three months. You can attend in-person or virtually. Attending committee meetings will give you and your caregiver or family member the chance to provide input on Molina and meet other members. If you would like more information or want to attend, contact Member Services.

Your Responsibilities

General Responsibilities

As a Cardinal Care member, you have some responsibilities. This includes the responsibility to:

- Follow this handbook, understand your rights, and ask questions when you do not understand or want to learn more.
- Treat your providers, Molina staff, and other members with respect and dignity.
- Choose your PCP and, if needed, change your PCP (see the *Your PCP* section).
- Be on time for appointments and call your provider's office as soon as possible if you need to cancel or if you are going to be late.
- Show your member ID Card whenever you get care and services (see the *Molina Healthcare Overview* section).
- Provide (to the best of your ability) complete and accurate information about your medical history and your symptoms.
- Understand your health problems and talk to your providers about treatment goals when possible.
- Work with your care manager and care team to create and follow a care plan that is best for you (see the *Care Coordination and Care management* section).
- Invite people to your care team who will be helpful and supportive to be included in your treatment.
- Tell Molina when you need to change your care plan.
- Get covered services from the Molina network when possible (see the *Your PCP* section).
- Get approval from Molina for services that require a service authorization (see the *Getting Approval for your Services, Treatments, and Drugs* section).
- Use the emergency room for emergencies only.
- Pay for services you get that are not covered by Molina or the Department.
- Report suspected fraud, waste, and abuse (see below).

Call Member Services at (800) 424-4518 (TTY/TDD: 711) to let them know if:

- Your name, address, phone number or email have changed (see the *Welcome* section).
- Your health insurance changes in any way (from your employer or workers' compensation, for example) or you have liability claims, like from a car accident.
- Your member ID card is damaged, lost, or stolen.
- You have problems with health care providers or staff.
- You are admitted to a nursing facility or the hospital.
- Your caregiver or anyone responsible for you changes.
- You join a clinical trial or research study.

Reporting Fraud, Waste, and Abuse

As a Cardinal Care member, you are responsible for reporting suspected fraud, waste, and abuse concerns and making sure you do not participate in or create fraud, waste, and abuse. Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is the practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain health care standards.

Examples of member fraud, waste, and abuse include:

- Falsely reporting income and/or assets to qualify for Medicaid.
- Permanently living in a state other than Virginia while receiving Cardinal Care benefits.
- Using another person's member ID card to get services.
- Providing services that are not medically necessary.
- Billing for services that were not provided.
- Changing medical records to cover up illegal activity.

Information on how to report suspected fraud, waste, or abuse is included in the table below

The Department's Fraud and Abuse hotline	
Phone	(804) 786-1066 Toll free: (866) 486-1971 TTY/TDD: 711
Email	**RecipientFraud@DMAS.virginia.gov**
Mail	Department of Medical Assistance Services, Recipient Audit Unit 600 East Broad St Suite 1300 Richmond, VA 23219

Virginia Medicaid Fraud Control Unit (Office of the Attorney General)	
Phone	**(804) 371-0779** Toll free: (800) 371-0824 TTY/TDD: 711
Email	**MFCU_mail@oag.state.va.us**
Fax	(804) 786-3509
Mail	Office of the Attorney General Medicaid Fraud Control Unit 202 North Ninth Street Richmond, VA 23219

Virginia Office of the State Inspector General Fraud, Waste, and Abuse Hotline	
Phone	**(800) 723-1615** TTY/TDD: 711
Email	**covhotline@osig.virginia.gov**
Fax	**(804) 371-0165**

Mail	State Fraud, Waste, and Abuse Hotline 101 N. 14th Street The James Monroe Building 7th Floor Richmond, VA 23219

Definitions

General Responsibilities

Addiction and Recovery Treatment Services (ARTS): A substance use disorder treatment benefit for members with addiction. Members can access a comprehensive continuum of addiction treatment services, such as inpatient services, residential treatment services, partial hospitalization, intensive outpatient treatment, Medication Assisted Treatment (MAT), substance and opioid use services, and peer recovery support services.

Adverse Benefit Determination: Any decision by the health plan to deny a service or a service authorization request for a member. This includes an approval for a service amount that is less than requested.

Appeal: A request by an individual (or someone they trust acting on their behalf) for the health plan to review a service request again and consider changing an adverse benefit determination made by the health plan about health coverage or covered services.

Authorized representative: A person who can make decisions and act on a member's behalf. Members can select a trusted family member, guardian, or friend to be their authorized representative.

Brand name drug: A medication that is made and sold by a single company. Generic versions of these drugs are sometimes available with the same ingredients but made by a different company.

Cardinal Care Managed Care Enrollment helpline: Assistance provided by an organization that contracts with DMAS to help individuals with enrollment activities and choosing a health plan. Cardinal Care Managed Care Enrollment Helpline services are free and may be provided by phone or online.

Cardinal Care: Virginia's Medicaid/FAMIS program, which includes the state's two prior Medicaid managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus), fee-for-service (FFS) Medicaid members, FAMIS Children, FAMIS MOMS and FAMIS PC.

Care Coordination: Help that the health plan provides to members so that members understand what services are available and how to get the health care or social services that they need. Care coordination is available to all members, including those who are not assigned a care manager and do not need or want care management.

Care Management: Ongoing support provided to members with significant health, social, and other needs by a health plan's care manager. Care management services include a careful review a member's needs, development of a Care Plan, regular communication with a care manager and the member's care team and help with getting health care and social services transitions between different health care settings.

Care Manager: A health professional that works for the health plan with special health care expertise that is assigned to and works closely with certain members with more significant needs. The care manager works with the member, the member's providers, and their family members/caregivers to understand what health care and social services the member needs, help them get the services they need and to support them making decisions about their care.

Care Plan: A plan that is developed and updated regularly by a member and their care manager that describes a member's health care and social needs, the services the member will get to meet their needs, how they will get these services, by whom, and in some cases, how frequently.

Care Team: A group of health care providers, including a member's doctors, nurses, and counselors, as selected by the member, who help the member get the care they need. The member and their caregivers are part of the Care Team.

CCC Plus Waiver: A home and community-based services (HCBS) waiver program in Virginia that provides care in the home and community instead of a nursing facility to members who qualify.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of the Medicaid and Medicare programs.

Copayment: A fixed dollar amount that a member may be required to pay for certain services. Most Molina members will not have to pay copayments for covered services.

Cover Virginia: Virginia: Virginia's statewide support center. Individuals can call (833) 5-CALLVA (TTY/TDD: (888) 221-1590) for free or visit Coverva.org/en to learn about and apply for health insurance, renew their coverage, update information, and ask questions.

Covered benefits: Health care services and prescription drugs covered by the health plan or DMAS, including medically necessary physical health services, behavioral health services, and LTSS.

Doulas: A trained individual in the community who provides support to members and their families throughout pregnancy, during labor and birth, and up to one year after giving birth.

Dual eligible member: A person who has Medicare and full Medicaid coverage.

Durable Medical Equipment (DME): Medical equipment and appliances, such as walkers, wheelchairs, or hospital beds, that members can get and use at home when medically necessary.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): A federally required benefit that members under age 21 are entitled to get. EPSDT provides comprehensive services to identify a child's condition, treat it, and make it better or prevent it from getting worse. EPSDT makes sure children and youth get needed preventive, dental, mental health, developmental, and specialty services.

Early Intervention (EI): Services for babies under the age of three who are not learning or developing like other babies. Services may include speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to support learning and development.

Eligible: Meeting conditions or requirements for a program.

Emergency Care (or Emergency Services): Treatment or services an individual gets for an emergency medical condition.

Emergency medical condition: When an illness or injury is so serious that an individual (or, as applicable, their unborn baby's) health, bodily functions, body organs, or body parts may be in danger if they do not get medical care right away.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to receive medical care. Members can get emergency medical transportation by calling 911.

Emergency room care: A hospital room staffed and equipped for the treatment of individuals that require immediate medical care and/or services.

Excluded services: Services that are not covered by the health plan or DMAS.

Family Access to Medical Insurance Security (FAMIS) Plan or FAMIS Children: A comprehensive health insurance program run by the federal and state government for uninsured children from birth through age 18 not eligible for Medicaid with income less than 200% of the federal poverty level.

FAMIS MOMS: A health insurance program run by the federal and state government for uninsured pregnant individuals with income eligibility the same as FAMIS children.

FAMIS Prenatal Care (FAMIS PC): A health insurance program run by the federal and state government for pregnant individuals who do not meet eligibility for Medicaid or FAMIS MOMS because of their citizenship or immigration status. Coverage begins during pregnancy and lasts through two months after the baby is born.

Fraud, Waste, and Abuse: Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is member or provider practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain health care standards.

Generic drug: A medication that is approved by the federal government to use in place of a brand name medication because they have the same ingredients and work equally.

Good cause reasons: Acceptable reasons to change health coverage. Examples of good cause reasons are: (1) an individual moves out of the state, or (2) the health plan is not able to provide the required medical services.

Grievance (or complaint): A written or verbal complaint that an individual makes to their health plan or an outside organization. Complaints can be concerns about accessibility, the quality of care, customer service, wait times, and privacy.

Habilitation services and devices: Services and devices that help individuals keep, learn, or improve skills and functioning for daily living.

Health assessment: An in-depth assessment completed by the care manager to help identify a member's health, social, and other needs, goals, and preferences. The Health Assessment helps guide the development of the Care Plan for members receiving care management.

Health insurance: A type of insurance coverage that pays for some or all of the member's care costs. A company or government agency makes the rules for when and how much to pay.

Health plan (or Plan): A Cardinal Care Medicaid/FAMIS managed care organization that contracts with a group of doctors, hospitals, pharmacies, other providers, and care managers. They all work together to get members the care and care coordination they need.

Health screening: A screening administered to all members by the health plan to help understand if the member would benefit from Care Management. The screening asks members about their health needs, social needs, medical conditions, ability to do everyday things, and living conditions.

Home health aide: Short term services provided to Medicaid members to support them with personal care. Home health aides do not have a nursing license or provide therapy.

Home health care: Health care services a member receives at home, including nursing care, home health aide services, physical/occupational therapy and other services.

Hospice services: Care to provide comfort and support for members (and their families) with a terminal prognosis — meaning the individual is expected to have six months or less to live.

A member with a terminal prognosis has the right to choose to stay in hospice. In hospice, a specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospital outpatient care: Care or treatment in a hospital that usually does not require an overnight stay.

Hospitalization: When an individual is admitted to a hospital as a patient to receive care. This is also known as inpatient hospital care.

Long-Term Services and Supports (LTSS): Services and supports that help elderly individuals and children or adults with disabilities meet their daily needs and maintain independence. Examples include assistance with bathing, dressing, eating, and other basic activities of daily life and self- care, as well as support for everyday activities such as laundry, shopping, and transportation. Members can get LTSS in the setting that is right for them: the home, the community, or a nursing facility.

Medicaid or FAMIS Fee-for-Service (FFS): The way in which DMAS pays providers for Medicaid or FAMIS services. Molina members who are not enrolled in managed care are enrolled in FFS.

Medicaid/FAMIS Managed Care: When DMAS contracts with a health plan to provide Medicaid/FAMIS benefits to members.

Medicaid: A health insurance program run by the federal and state government that provides free or low-cost health coverage and care to low-income individuals.

Medically necessary: Services, supplies, or drugs needed to prevent, diagnose, or treat a medical condition or its symptoms. Medically necessary also means that services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

Medicare: The federal health insurance program for individuals 65 years of age or older, some individuals under age 65 with certain disabilities, and individuals with end-stage renal disease (generally meaning those with permanent kidney failure who need dialysis or a kidney transplant) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and provider visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A, Medicare Part B, or Medicaid.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.

Member services: A department at the health plan responsible for answering questions about membership, benefits, appeals, and complaints.

Network: A group of doctors, clinics, hospitals, pharmacies, and other providers contracted with the health plan to provide care to members.

Network provider (or participating provider): A provider or facility that contracts with the health plan to provide covered health care services to members.

Network pharmacy: A drugstore that has agreed to fill prescription drugs for the health plan's members. In most cases, prescription drugs are covered only if they are filled at one of the health plan's network pharmacies.

Nursing facility: A medical care facility that provides care for individuals who cannot get their care at home but who do not need to be in the hospital. Members must meet specific criteria to live in a nursing facility.

Out-of-network provider (or non-participating provider): A provider or facility that is not employed, owned, or operated by the health plan and is not under contract to provide covered health care services to members.

Patient pay: The amount a member may have to pay for LTSS based on their income. The local DSS calculates the member's patient pay amount if they live in a nursing facility or receive CCC Plus waiver services and have an obligation to pay a portion of care.

Personal Care Aide services: Services provided by a Personal Care Aide that help members with personal care (bathing, using the toilet, dressing, or carrying out exercises) on an ongoing or long- term basis.

Premium: The monthly amount a member may be required to pay for their health insurance every month. Molina Medicaid members do not need to pay any premiums for coverage. If a member is enrolled in a health plan but does not qualify for coverage because information they reported to DMAS or the health plan was false or because they did not report a change, the member may have to pay DMAS back the cost of the monthly premiums. The member will have to repay DMAS even if they did not get services during those months.

Prescription drug coverage (or covered drugs): Prescription medications covered (paid for) by the health plan. The health plan also covers some over-the-counter medications.

Prescription drugs: Medications that by law, members can only obtain through a provider prescription.

Primary Care Provider (PCP) (or Primary Care Physician): A doctor or nurse practitioner who helps members get and stay healthy by taking care of their needs. PCPs provide and coordinate health care services.

Private duty nursing services: Skilled in-home nursing services provided by a licensed registered nurse (RN), or by licensed practical nurse under the supervision of an RN, to CCC Plus waiver members who have serious medical conditions or complex health care needs. Children and youth under age 21 can also get private duty nursing services under the EPSDT benefit.

Prosthetics and orthotics: Medical devices ordered by a member's provider. Covered items include, but are not limited to: arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

Provider: Doctors, nurse practitioners, specialists, and other individuals who are authorized to provide health care or services to members. Many kinds of providers participate in each health plan's network.

Provider Services (or Physician services): Care provided by an individual licensed under Virginia state law to practice medicine, surgery, or behavioral health.

Referral: Approval from a PCP to use other providers in the health plan's network. A PCP's referral is required before a member can see other network providers.

Rehabilitation services and devices: Treatment to help individuals recover from an illness, accident, injury, or major operation.

Service authorization (or Preauthorization): Approval that may be needed before a member can get certain services, treatments, or prescription drugs. Service authorizations are requested by providers to the health plan to help make sure that the provider can be paid for the services they provide to the member.

Skilled nursing care: Skilled care or treatment that can only be provided by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings, or rapidly changing health status.

Skilled Nursing Facility (SNF): A facility with staff and equipment to provide skilled nursing care, in most cases, skilled rehabilitative services and other related health services.

Specialist: A provider who has additional training on services in a specific area of medicine, like a surgeon. The care members receive from a specialist is called specialty care.

State Fair Hearing: The process where a member appeals to the state about a decision made by the health plan. Individuals can file a State Fair Hearing appeal if the health plan does not respond to or make a decision on an individual's appeal on time, or if the individual does not agree with the plan's appeal decision.

Urgent care: Care an individual gets for a sickness or an injury that needs medical care quickly and could turn into an emergency.

Notice of Nondiscrimination

Molina Healthcare does not discriminate (or treat you differently) based on race, color, national origin, age, disability, or sex. Molina Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Molina provides:

- Free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services at **(800) 424-4518** (TTY/TDD: 711). This call is free.

If you think Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, DMAS, 600 E. Broad St., Richmond, VA 23219, Telephone: **(804) 786-7933** (TTY/TDD: (800) 343-0634).

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf** or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201;

(800) 368-1019 (TTY/TDD (800) 537-7697). Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

Other languages and formats

If you need this handbook in large print, in other formats or languages, read aloud, or if you need a paper copy, call Molina Member Services at **(800) 424-4518** (TTY/TDD: 711).

If you have alternative hearing or speech communication needs, you can access a Telecommunications Relay Services (TRS) operator by dialing 711. They can assist you with whatever you need, which won't cost you anything. We also provide auxiliary aids and services free of charge upon request. You can visit us anytime online at **MolinaHealthcare.com**.

English

Language assistance services are available to you free of charge. Call (800) 424-4518 (TTY/TDD: 711) if you need any of these services. Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or religion.

Spanish

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 424- 4518 (TTY/TDD: 711) Molina Healthcare cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 424-4518 (TTY/TDD: 711)번으로 전화해 주십시오. Molina Healthcare 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Vietnamese

Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho bạn. Gọi (800) 424-4518 (TTY/TDD: 711) nếu quý vị cần bất kỳ dịch vụ nào trong số này. Molina Healthcare tuân thủ luật dân quyền Liên bang hiện hành và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, khuyết tật, giới tính hoặc tôn giáo.

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 (800) 424-4518 (TTY/TDD: 711). Molina Healthcare 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人 (800) 424-4518 (TTY/TDD: 711)。

Arabic

إذا كنت بحاجة إلى أي من هذه الخدمات. تلتزم (TTY / TDD: 711) **تتوفر لك خدمات المساعدة اللغوية مجانا.** اتصل بالرقم (800) 424-4518 بقوانين الحقوق المدنية الفيدرالية المعمول بها ولا تميز على أساس العرق أو اللون أو الأصل القومي أو العمر أو الإعاقة أو Molina Healthcare الجنس أو الدين.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 424-4518 (TTY/TDD: 711). Sumusunod ang Molina Healthcare sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(800) 424-4518 (TTY/TDD: 711) (መስማት ለተሳናቸውMolina Healthcare የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው ኣያገልም።

Urdu

زبان کی معاونت کی خدمات آپ کے لئے مفت دستیاب ہیں۔ اگر آپ کو ان میں سے کسی بھی خدمات کی ضرورت (800) 424-4518 ہے تو

کال کریں۔ مولینا ہیلتھ کیئر قابل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتی ہے اور نسل ، رنگ ، قومی (711 : ٹی ٹی وائی / ٹی ڈی ڈی

اصل ، عمر ، معذوری ، جنس یا مذہب کی بنیاد پر امتیاز ی سلوک نہیں کرتی ہے۔)

French

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 424-4518 (TTY/TDD: 711). Molina Healthcare respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 424-4518 (TTY/TDD: 711) Molina Healthcare соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной пдлежности, возраста, инвалидности или пола.

Hindi

भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कॉल (800) 424-4518 (TTY/TDD: 711) यदि आपको इनमें से किसी भी सेवा की आवश्यकता है। मोलिना हेल्थकेयर लागू संघीय नागरिक अधिकार कानूनों का अनुपालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, लिंग या धर्म के आधार पर भेदभाव नहीं करता है।

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 424-4518 (TTY/TDD: 711). Molina Healthcare erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Bassa

Dè ɖɛ nìà kɛ dyéɖé gbo: jǔ ké m[àsɔ ɔ -wùɖù-po-nyɔ] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ ɓɛ ìn m gbo kpáa. á (800) 424-4518 (TTY/TDD: 711). Molina Healthcare Nyɔ ɓěɛ kpɔ nyɔǔn-dyù gbo- gmɔ -gmà ɓěɔ dyi ké wa ní ge nyɔǔn-dyù mú dyììn ɖé ɓóɖó-dù nyɔɔ sɔ kɔ ɛ mú, mɔɔ kà nyɔɔ dyɔɔ -kù nyu nìɛ kɛ mú, mɔɔ ɓóɖó ɓɛ nyɔɔ sɔ kɔ ɛ mú, mɔɔ zɔjĩ kà nyɔɔ ɖǎ nyuɛ mú, mɔɔ nyɔɔ mɛ kɔ dyíɛ mú, mɔɔ nyɔɔ mɛ mɔ gàa, mɔɔ nyɔɔ mɛ mɔ màa kɛɛ mú.

MOLINA® HEALTHCARE

Your Extended Family.

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