Welcome to Molina Healthcare

Member Handbook

Ohio Medicaid Managed Care Molina Healthcare of Ohio

Molina Healthcare posts the most recent copy of your Member Handbook online. Visit MolinaHealthcare.com/OHMedicaidHandbook to view this Handbook and other important member materials.

MolinaHealthcare.com

MOLINA® HEALTHCARE

Important Notices for Members

How to Get this Information in Other Languages and Formats

If you have a problem reading or understanding this information or any other Molina Healthcare information, please contact our Member Services toll-free at (800) 642-4168 (TTY for the hearing impaired: (800) 750-0750 or 711) for help at no cost to you.

We can explain this information, in English or in your primary language.

You can get this document for free in other formats, such as large print, braille, or audio.

Call toll-free (800) 642-4168 Monday through Friday, 7 a.m. to 8 p.m. For hearing impaired, call TTY (800) 750-0750 or 711.

Notice of Nondiscrimination

Molina Healthcare of Ohio (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

If you believe you have been discriminated against, you can file a complaint. You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, our Civil Rights Coordinator is available to help you.

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802
(866) 606-3889, or TTY 711

You can also email your complaint to Civil.Rights@MolinaHealthcare.com. Or, fax your complaint to (888) 295-4761.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Or file a complaint by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
1–800–868–1019 or TTY 800–537–7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You may also file an appeal or complaint directly with ODM Office of Civil Rights by email (ODM_EEO_EmployeeRelations@medicaid.ohio.gov), by fax (614-644-1434) or by mail at:

The Ohio Department of Medicaid, Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

You may obtain this information in different languages, free of charge. Free aids and services, such as sign language interpreters and written information in alternative formats, are available to you. Call (800) 642-4168 (TTY: 711).

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-642-4168 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-642-4168 (TTY: 711).

注意：如果您說國語，您可以獲得免費的語言協助服務。請撥打 1-800-642-4168（電傳打字機 (TTY)：711）。

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-642-4168 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-642-4168 (رقم هاتف الصم والبكم: 711).

BYITONDERE: Niba uvuga i Kinyarwanda, serivisi y'ubufasha mu ndimi, ku buntu, urayihabwa. Hamagara 1-800-642-4168 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-642-4168 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-642-4168 (TTY : 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-642-4168 (TTY: 711).

温馨提示：如果您使用中文，可以免费获得语言支持服务。请致电 1-800-642-4168（TTY 用户请拨打：711）。

توجه: اگر به زبان دری صحبت می کنید، برای شما خدمات کمک لسان طور رایگان موجود است. به 1-800-642-4168 (TTY: 711) زنگ بزنید.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-642-4168 (መስማት ለተሳናቸው: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-642-4168 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-642-4168 (телетайп: 711).

FIIRO GAAR AH: Hadii aad ku hadasho Ingiriisiga, adeega kaalmada luuqada, oo bilaa lacag ah, ayaa kuu diyaar ah. 1-800-642-4168 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-642-4168 (टिटिवाइ: 711) ।

Table of Contents (List of Information in this Handbook)

In this Molina Healthcare Member Handbook, you will find helpful information about:

Molina Healthcare posts the most recent copy of your Member Handbook online. Visit MolinaHealthcare.com/OHMedicaidHandbook for this Handbook and other important member materials.

ATTENTION: If you do not speak English, language services, free of charge, are available to you. Call toll-free (800) 642-4168 Monday through Friday, 7 a.m. to 8 p.m. For hearing impaired, call TTY (800) 750-0750 or 711. The call is free.

Welcome to Molina Healthcare

Medicaid Managed Care

Welcome to Molina Healthcare. You are now a member of a health care plan, also known as a managed care organization (MCO). Molina Healthcare provides health care services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, children, older adults, and individuals with disabilities.

Molina Healthcare may not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, veteran status, ancestry, disability, genetic information, health status, or the need for health services.

How to Use This Book

This Handbook is for members of Molina Healthcare's Medicaid plan.

This Member Handbook can tell you:

- About your Medicaid health plan.
- About Medicaid services and supplies covered by Molina.
- About extra benefits covered by Molina.
- How to get the services you need, including services for special health care needs.
- How to contact us.
- Your rights and responsibilities as a member.

The most current version of the Member Handbook is available at MolinaHealthcare.com/OHMedicaidHandbook.

Where to Get Covered Services

It is important to remember that you must receive services covered by Molina Healthcare from facilities and providers in Molina Healthcare's network. Providers in the Molina Healthcare's network agree to work with your health plan to give you needed care.

The only time you can use providers that are not in Molina Healthcare's network is for:

- emergency services,
- federally qualified health centers (FQHC)/rural health clinics (RHC),
- qualified family planning providers,
- an out of network provider that Molina Healthcare has approved you to see

Provider Directory

The Provider Directory lists all our network providers as well as other non-network providers you can use to receive services.

There are 3 ways to view the Provider Directory:

1. *Log on to My Molina*
   Visit MyMolina.com or download the My Molina Mobile app to find a provider with our online search tool. If you don't have a My Molina username, you must register first.

2. *Ask for a printed copy of the Provider Directory*
   You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your member identification (ID) card.

3. *View the Provider Directory online*
   You can also visit our website at MolinaProviderDirectory.com/OH to view up to date provider network information, or call Member Services at (800) 642-4168 TTY (800) 750-0750 or 711) Monday through Friday, 7 a.m. to 8 p.m. for help.

Identification (ID) Cards

You should have received a Molina Healthcare membership ID card. Each member of your family who has joined Molina Healthcare will receive their own card. Each card is good for as long as the person is a member of Molina Healthcare.

You may have received a Medicaid card monthly before you enrolled with Molina Healthcare as your Medicaid plan. The Molina Healthcare member ID card we sent you replaces your monthly Medicaid card. You will not receive a new card each month.

Keep your ID card with you at all times. If you did not get an ID card in the mail, visit MyMolina.com or call Member Services.

Always Keep Your ID Card(s) with You

You will need your ID card each time you get medical services. This means that you need your Molina Healthcare ID card when you:

- see your primary care provider (PCP)
- see a specialist or other provider
- go to an emergency room
- go to an urgent care facility
- go to a hospital for any reason
- get medical supplies
- get a prescription
- have medical tests
- schedule transportation

If you lost your ID card, register for MyMolina.com today. You can request a new ID card and update your information. You can even print a temporary ID card to use while we send you a new one. Or, call Member Services for help getting a new ID card.

Check your ID card for the name of your Primary Care Provider (PCP). If the name on the card is not your current PCP, we can send you an updated ID card. You can update this information at MyMolina.com or by calling Member Services.

If you are pregnant, you need to let Molina Healthcare know. You must also call when your baby is born so we can send you a new ID card for your baby.

Call your Molina Healthcare Member Services as soon as possible at (800) 642-4168 (TTY for the hearing impaired (800) 750-0750 or 711) if:

- you have not received your card(s) yet
- any of the information on the card(s) is wrong
- you lose your card(s)
- you have a baby

New Member Information

If You Have Health Services Already Approved or Scheduled

If you have health care services already approved or scheduled, it is important that you call Member Services immediately. In certain situations, and for a specified time period after you enroll, you may be allowed to receive care from a provider that is not a Molina Healthcare network provider.

You must call Molina Healthcare before you receive the care. If you do not call us, you may not be able to receive the care and/or the claim may not be paid.

For example, you need to call Member Services if you have the following services already approved or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a primary care or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies, and nursing

Approval for Health Services and Supplies (Prior Approval)

Your provider must ask Molina Healthcare to approve some treatments and services before you can get them. This is called a "prior approval (PA)." It is also sometimes called a "prior authorization."

Most services are available to you without PA. However, some services do require it.

If a service requires PA, Molina Healthcare's medical staff and your doctor review the medical need of your care before the service is given. They will make sure it is the right type of care for your health condition.

For a list of covered services that do and do not require PA, see the List of Covered Services chart in this Member Handbook. You may also visit MolinaHealthcare.com or call Member Services.

When our plan makes changes to the list of services that need PA, we will post an update online at www.MolinaHealthcare.com/OHMedicaidPA.

Choosing a Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is a doctor who knows you well and takes care of all your medical needs. Your PCP is an individual provider, provider group practice, advanced practice nurse or advanced practice nurse group practice trained in obstetrics/gynecology (OB/GYN), family medicine (general practice), internal medicine, or pediatrics.

Your PCP will work with you to direct your health care. Your PCP will do your check-ups, shots and treat you for most of your routine health care needs. If needed, your PCP will send you to providers, specialists or admit you to the hospital.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your Molina Healthcare ID card.

It's important to have a doctor who makes you feel comfortable. You can pick one for you and another for others in your family, or one who sees all of you.

You must choose a primary care provider (PCP) from Molina Healthcare Provider Directory.

Go to MolinaProviderDirectory.com/OH to get started. The Provider Directory lists our network providers' names, addresses, phone numbers, professional qualifications, specialties, the medical schools they attended, where they completed their residencies and their board certifications.

If you do not choose a doctor, Molina will do it for you. We will choose a doctor based on your address, preferred language and doctors your family has seen in the past.

Scheduling Your First Visit

Call right away to schedule a visit with your doctor. Your doctor can help you learn more about your health.

Your doctor will

- Treat you for most of your routine health care needs.
- Review your tests and results.
- Prescribe medications.
- Refer you to other doctors (specialists).
- Admit you to the hospital if needed.

Changing Your Primary Care Provider (PCP)

If you want to change your PCP, you must first call Member Services to ask for the change. Or you can log in to the My Molina phone app or MyMolina.com to change your PCP. You can find a PCP using our online Provider Directory at any time. If you need to change your PCP, you may do so monthly.

Molina Healthcare will send you a new ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP.

For the names of the PCPs in Molina Healthcare, you may look in your Provider Directory if you requested a printed copy, on our website at MolinaProviderDirectory.com/OH, or you can call the Molina Healthcare Member Services department at (800) 642-4168 (TTY for the hearing impaired: (800) 750-0750 or 711) for help.

If You Need to See an Out-of-Network Doctor

You must see a provider that is part of Molina Healthcare's network. You must be in the Molina Healthcare service area and see a doctor that is part of Molina Healthcare's network to get services.

Providers that are not in Molina Healthcare's network are called "out-of-network" providers. You must get an approval to get services from an out-of-network provider. Call your PCP to get an approval. If you don't get an approval, you will have to pay for these services.

Getting Care Outside the Molina Healthcare Service Area

Molina Healthcare's service area covers all counties in Ohio. If you are away from Molina Healthcare's service area and need emergency care, go to the nearest emergency department. You can go to any facility that provides emergency services to get emergency care. If you are outside of the Molina Healthcare service area and you need non-emergency medical care, your provider must first contact Molina Healthcare to get approval before providing any services.

Frequency Limitations

Your managed care organization will review all requests for services from your provider. If you have a question about whether a service is covered, please call Member Services at (800) 642-4168 (TTY (800) 750-0750 or 711) Monday through Friday, 7 a.m. to 8 p.m.

Second Opinions

If you do not agree with your provider's plan of care for you, you have the right to a second opinion from another provider. If the provider you talk to is an out-of-network provider, prior approval is needed. This service is at no cost to you. Call Member Services to learn how to get a second opinion.

Services Covered by Molina Healthcare

As a Molina Healthcare member, you will receive all medically necessary Medicaid-covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.

The following lists tell you which services need prior approval (PA) and which do not. Not all services that need prior approval are included in the list. Prior approval is explained in the New Member Information section of this Member Handbook.

For more information, or if you have questions, call Member Services.

Covered Services at a Glance

Below is a quick list of services and supplies covered by Molina Healthcare.

The services and supplies are listed alphabetically (from A to Z). For more detailed information about covered services, see the List of Covered Services on the following pages.

Key
You can use these symbols to tell if a service may need prior approval, or if there may be limitations to the service.

* - Prior authorization (PA) may be required.
¥ - The service may be limited to a certain number of visits or to certain members.

- Acupuncture – to treat certain conditions* ¥
- Allergy services*
- Ambulance and wheelchair van transportation*
- Autism Spectrum Disorder services*
- Behavioral Health Services (including mental health and substance use disorder treatment services)*
- Certified nurse midwife services
- Certified nurse practitioner services
- Chemotherapy services*
- Chiropractic (back) services* ¥
- Dental services*
- Developmental therapy services for children aged birth to six years* ¥
- Diagnostic services (x-ray, lab)*
- Durable medical equipment (DME)*
- Emergency services
- Family planning services and supplies
- Federally Qualified Health Center or Rural Health Clinic services

- Free-standing birth center services at a free-standing birth center
- Gynecological services (OB/GYN)*
- Home health services*
- Hospice care (care for terminally ill, e.g., cancer patients)*
- Inpatient hospital services*
- Medical nutrition therapy (MNT) services*
- Nursing facility services*
- Maternity care – prenatal and postpartum including at-risk pregnancy services
- OhioRISE program services ¥
- Outpatient hospital services*
- Pharmacist services (under Medical benefit)
- Physical and occupational therapy ¥
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Physician services*
- Podiatry (foot) services*
- Preventive mammogram (breast) and cervical cancer (pap smear) screenings
- Primary care provider services
- Renal dialysis (kidney disease) services
- Respite services* ¥
- Screening and counseling for obesity ¥
- Services for children with medical handicaps (Title V)* ¥
- Shots (immunizations)
- Specialist services*
- Speech and hearing services, including hearing aids* ¥
- Telehealth services ¥
- Tobacco cessation services, including tobacco cessation counseling and FDA approved medications for tobacco cessation
- Transportation
- Vision (optical) services, including eyeglasses
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well-adult exams

List of Covered Services

Below is the full list of services and supplies covered by Molina Healthcare.

Covered Services	
Services covered by our plan	**Limitations and exceptions**
Acupuncture – to treat certain conditions	Acupuncture coverage is limited to treatment of: • Low back pain • Migraine headaches • Cervical (neck) pain • Osteoarthritis of the hip • Osteoarthritis of the knee • Nausea or vomiting related to pregnancy or chemotherapy • Acute pain after surgery PA is not required for the first 30 visits in a calendar year. PA is required for 31 or more visits in a calendar year.
Allergy services	Some allergy services may require PA.
Ambulance and wheelchair van transportation	PA is not required for emergency transportation. Some non-emergency transportation may need a PA.
Autism Spectrum Disorder services	PA may be required for services requested in excess of state Medicaid plan limits. Services are covered as mandated by 42 U.S.C. 1396d(a) and ORC 1751.84 for members with primary diagnosis of Autism Spectrum Disorder.

Behavioral Health Services (including mental health and substance use disorder treatment) • Assessment • Crisis intervention • Counseling and psychotherapy • Psychiatric medication management • Medication-assisted treatment for addiction • Methadone administration • Emergency Department behavioral health services • Child and Adolescent Needs and Strengths (CANS) assessment • Mobile response stabilization services (MRSS) OhioRISE is a specialized managed care program for youth with complex behavioral health needs. See more under "OhioRISE program services" in this chart.	PA is not required to begin getting services with a network provider. PA is required for intensive services such as partial hospitalization or substance use disorder residential treatment. Contact your provider or Molina Healthcare for more information. You can call the 24-Hour Behavioral Health Crisis Line if you need help right away or are not sure what to do for a mental health problem. Call (888) 275-8750 (TTY 711) at any time.
Certified nurse midwife services	PA is not required.
Certified nurse practitioner services	PA is not required.
Chemotherapy services	PA is required.
Chiropractic (back) services • Diagnostic x-rays • Adjustments of the spine to correct alignment • Office visits	For members age 20 and younger, PA is not required for the first 30 visits in a calendar year. After 30 visits, PA is required. For members age 21 and older, PA is not required for the first 15 visits in a calendar year. After 15 visits, PA is required. Office visits are covered when performed by a chiropractor. Molina covers four office visits per calendar year. Please note, the limit of four office visits is counted separately from the limits listed above for adjustments of the spine.

Dental services • Routine cleaning and exam once every 6 months for all ages • Additional dental services, including fillings, crowns, oral surgery, x-rays and root canals • Removal of impacted wisdom teeth and emergency tooth re-implantation for adults • Dentures, partial plates and braces	Routine services do not require PA. Dental services other than routine care require PA. For members with periodontal disease, who have already received scaling and root planning services: You may be eligible to receive additional periodontal services. You may receive up to 2 periodontal maintenance services per 12 months. You can receive these services up to 24 months after receiving initial periodontal scaling and root planning services. Pregnant members are eligible for one additional cleaning up to 3 months after their due date. This means they are eligible for a total of 3 cleanings within 365 days from the start of their pregnancy.
Developmental therapy services for children aged birth to six years	In an outpatient setting, you get 30 visits in each 12-month period without PA. PA is required after 30 visits in a 12-month period.
Diagnostic services (x-ray, lab)	Selected diagnostic services (including CT Scans, MRIs, MRAs, PET Scans and SPECT) require PA. PA is not required for ultrasounds.
Durable medical equipment (DME) The equipment you need for certain medical conditions is covered, such as: • Breast pump • Breast milk storage bags • Blood pressure equipment • Wheelchairs • Oxygen equipment • Canes, crutches and walkers	Some DME items require PA. Plan covers 1 manual breast pump every 2 years. Plan covers 1 electric breast pump every 2 years. PA is not required for milk storage bags.
Emergency services An emergency is a medical problem you think is so serious that it must be treated right away by a doctor. Emergency services are always covered. To learn more, see page 34.	PA is not required.

Family planning services and supplies • Exam and medical treatment • Lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Supplies (condom, foam, film, diaphragm, cap) • Treatment for sexually transmitted infections (STIs)	PA is not required.
Federally Qualified Health Center or Rural Health Clinic services • Office visits for primary care and specialist services • Physical therapy services • Speech pathology and audiology services • Dental services • Podiatry services • Vision services • Chiropractic services • Transportation services • Mental health services	PA is not required.
Free-standing birth center services at a free-standing birth center You can call Member Services to see if there are any qualified centers in your area.	PA is not required.
Gynecological services (OB/GYN) • Pelvic exam and pap test	Preventive services do not require PA. Other services may require PA.
Home health services • Home health aide and/or nursing services • Physical therapy, occupational therapy, and speech therapy • Private duty nursing • Home infusion therapy • Medical and social services • Medical equipment and supplies	PA is required after the initial evaluation plus the first 6 visits.

Hospice care (care for terminally ill, e.g., cancer patients) While you are receiving hospice care, Molina Healthcare will also cover: • Drugs to treat symptoms and pain • Short-term respite care • Home care • Nursing facility care	Some hospice care services may require PA.
Inpatient hospital services • Semi-private room, or private room if medically necessary • Meals, including special diets • General and special nursing care • Costs of special care units, such as intensive care • Drugs and medications prescribed in accord with our Preferred Drug List • Lab tests • X-rays • Needed surgical and medical supplies, including anesthesia • Physical, occupational and speech therapy • Operating and recovery room services • Inpatient substance abuse services	Inpatient hospital services (except for emergency admissions) and elective admissions, including pregnancy delivery services, and all inpatient surgeries, require PA. Notification to Molina Healthcare is required within 24 hours of admission or by the next business day for emergency admissions.
Medical nutrition therapy (MNT) services	Some medical supplies require PA. PA is required in a home health setting.
Nursing facility services • A semi-private room, or a private room if medically necessary • Meals, including special diets • Nursing services • Physical, occupation and speech therapy • Drugs you get as part of your plan of care • Medical and surgical supplies • Lab tests • X-rays • Equipment, such as wheelchairs Nursing facility stays are covered unless ODM determines that you will return to fee-for-service. If you need nursing services, call Member Services for information on available providers.	Nursing facility services require PA.

Maternity care - prenatal and postpartum including at-risk pregnancy services • Prenatal care • Postpartum care • At-risk pregnancy care management	PA is not required.
OhioRISE program services • Care Coordination • Mobile response stabilization services (MRSS) • Intensive home-based treatment (IHBT) • Behavioral health respite • Psychiatric residential treatment facility (PRTF) (Coming in January 2023)	A member may be eligible for OhioRISE services if they: • Are younger than age 21; and • Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) tool
Outpatient hospital services • Services in an emergency department or outpatient clinic • Outpatient surgery • Chemotherapy • Lab and diagnostic tests • Mental health care • X-rays • Medical supplies, such as splits and casts	Some outpatient services require PA.
Pharmacist services (under Medical benefit)	PA is not required.
Physical and occupational therapy	In an outpatient setting, you get 60 visits in each 12-month period for any physical and occupational therapy services without PA.
Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source	PA is not required.
Physician services	Routine and preventive care visits do not require PA with a network primary care physician. Some services may require PA.

Podiatry (foot) services • Diagnosis of injuries and diseases of the foot • Surgical treatment • Routine foot care	Some podiatry services require PA.
Preventive mammogram (breast) and cervical cancer (pap smear) screenings	PA is not required.
Primary care provider services Your PCP will provide all routine care services, such as: • Yearly well exams • Healthchek • Preventive screenings • Immunizations • Colds/flu • Sore throat • Earache • Rash • Joint pain • Pregnancy tests	PA is not required.
Renal dialysis (kidney disease) services • Inpatient and outpatient dialysis treatments • Home dialysis supplies	PA is not required.
Respite services are covered for members age 20 and younger who: • Have significant long-term care needs • Have significant behavioral health needs	Respite services require PA. The plan covers up to 100 hours of respite services per year, per member.
Screening and counseling for obesity	PA is not required. Screening and counseling for obesity requires a referral by a provider.
Services for children with medical handicaps (Title V)	Some services require PA.
Shots (immunizations) • Vaccines for children age 20 and younger • Flu shots • Hepatitis B vaccine • COVID-19 vaccines	PA is not required.

Specialist services Consultation, diagnosis and treatment by specialist provider	Office visits to see a specialist do not require PA. Some specialist services do require PA.
Speech and hearing services, including hearing aids • Hearing and balance tests • Hearing aids, batteries and accessories • Speech therapy	In an outpatient and home setting, you get 30 visits in each 12-month period for any combination of speech and audiology therapy services without PA. PA is required after 30 visits in a 12-month period. Some hearing aids may require PA.
Telehealth services Virtual visits with health providers using your smartphone, tablet, or computer.	Check with your health care provider to see if they offer telehealth services. Adult Molina Healthcare members can get virtual care from Teladoc. No appointment is needed to get a virtual visit with a doctor through Teladoc. For more information about telehealth and Teladoc, see page 33.
Tobacco cessation services, including tobacco cessation counseling and FDA approved medications for tobacco cessation. Call the Ohio Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669) and speak with an intake specialist to help quit tobacco.	PA is not required.
Transportation Rides to and from places where you get covered services at no cost to you, including: • If you **must** travel more than 30 miles to see a network provider • Extra benefit of 30 one-way trips every calendar year to the doctor, dentist, WIC and Medicaid renewal appointments • Call **(866) 642-9279** 2 business days before your appointment to schedule a ride. See page 26 to learn more.	PA is not required.

Vision (optical) services, including eyeglasses • One eye exam every 12 months • Replacement frames and lenses every 12 months due to normal wear and tear or when medically necessary. • Expanded selection of frames to choose from at no cost to you	PA is not required. Contact lenses are covered as needed if medically necessary. IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.
Well-child (Healthchek) exams for children under the age of 21 Checkups, immunizations and other services for children age 20 and younger. See page 31 to learn more.	PA is not required.
Yearly well-adult exams	PA is not required.

Your Extra Benefits

Molina Healthcare also offers extra services and/or benefits to their members. Please see the Your Extra Benefits insert included with your Member Handbook that explains these extra services.

The Your Extra Benefits information is included with your new member materials such as your member ID card.

You can also view the Your Extra Benefits insert online at MolinaHealthcare.com/OHMedicaidHandbook.

Molina Healthcare offers reward programs like Molina Rewards 4 Health, which reward members for getting certain health visits on time or meeting their health goals.
Visit MolinaHealthcare.com/OHMedicaidMember for more information.

Transportation Services

As a Molina Healthcare member, you get transportation benefits. You get 30 one-way trips every calendar year to covered, medically necessary appointments.

When can I use this benefit?
You can use this benefit to get to and from:

- Scheduled visits for covered services like doctor, dentist, behavioral health, or non-emergency hospital visits.
- Women, Infants, and Children (WIC) appointments.
- Medicaid renewal appointments.
- Your local pharmacy, food bank, grocery stores, or even grocery pick-up.*

* To use your rides for a grocery store pickup, place an online order with your grocery store. Select the date and time for your pickup. Then call (866) 642-9279 (TTY 711) to schedule your trip. Tell the transportation scheduling line that you want to use a ride to pick up groceries. The driver will go directly to the store, pick up the groceries (curbside only), and deliver the groceries to your address. This uses one of your trips for the year.

How do I schedule transportation?
Call (866) 642-9279 (TTY 711) as soon as possible. You can schedule a ride up to 30 days before your appointment. Molina Healthcare may not be able to schedule transportation for you if you do not call at least 2 business days before your appointment.

When you call us, your transportation representative will determine the best option for you. You can view the flexible options we offer in the Your Extra Benefits information included with your new member materials or online at MolinaHealthcare.com/OHMedicaidTransportation.

If you need special help, tell the transportation representative when you call. The transportation representative will make best efforts to accommodate your needs.

If you need to stop at the pharmacy, tell your transportation representative when you schedule your trip. You can stop at the pharmacy after a doctor's visit, or as a standalone trip. If you will go to the pharmacy after a doctor's visit, ask your doctor to call the pharmacy so your prescription is ready when you get there.

If I need a ride today, how can I schedule transportation?
If you are sick now and need a same-day visit to your doctor or an urgent care center, we will make best efforts to schedule a ride for you. We will also make best efforts to schedule a same-day ride if you are discharged from the hospital and need a ride home.

Call (866) 642-9279 (TTY 711) as soon as possible.

Can I schedule transportation with a phone app?
You can schedule and manage your trips with the Access2Care phone app. You can download the app by searching "A2C" on the iPhone App Store or Google Play for Android.

With the app, you can:

- Get text reminders and alerts on trip status
- See your vehicle location in real time
- Schedule, change, or cancel trips
- Save locations like your home or doctor's office
- Call your provider or the transportation scheduling line

Can I get a ride to my child's doctor visits?
If your child is a member of Molina Healthcare, you can get a ride to appointments with his or her provider. If you schedule an appointment with your child's provider, but your child will not be at the appointment, you can still get a ride. Tell the transportation representative about your situation when you call.

If you need to ride with a child who uses a car seat, you must bring a car seat for each child who needs one. The driver will not provide a car seat.

Can I bring someone with me for my trip?
Yes. You can bring one additional passenger with you.

If you need to bring children with you, tell the transportation representative when you call. The transportation representative will make best efforts to accommodate your needs.

If you need to ride with a child who uses a car seat, you must bring a car seat for each child who needs one. The driver will not provide a car seat.

Can I get rides in addition to my extra benefit of 30 one-way trips?
If you must travel 30 miles or more from your home to receive covered health care services, Molina Healthcare will provide transportation to and from the provider's office. Please call (866) 642-9279 at least 2 business days before your appointment for help.

For provider visits closer than 30 miles, you may use your benefit of 30 one-way trips each calendar year.

If you rely on a wheelchair or are going to a dialysis, chemotherapy, or radiation appointment, your trip will always be covered. This type of trip does not use your extra benefit of 30 one-way trips for the year.

In addition to the transportation assistance that Molina Healthcare provides, you can get transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program. Call your county department of job and family services for questions or assistance with NET services.

How do I cancel a scheduled ride?
If you need to cancel a scheduled ride, call to let us know at least 24 hours before your appointment.

If you don't cancel 24 hours ahead of a scheduled trip, you may lose one of your 30 one-way trips for the year. You may also lose a scheduled trip if the driver arrives and you do not come to the vehicle.

If you have a complaint about transportation services, call Member Services. The phone number is on your member ID card.

Care Management Services

Molina Healthcare offers care management services. Our care management program can help you manage health care conditions like:

- Asthma
- Behavioral health disorders
- Cancer
- Chemical dependency
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CAD)
- Developmental disabilities
- Diabetes
- High blood pressure
- Pain management
- Pregnancy

Our care management program can also help you with:

- Housing
- Food
- Utilities
- Safety in or around your home

If you have certain health conditions or need access to social resources, Molina Healthcare may recommend care management services to you. You and your provider can also call Member Services if you think care management services could help you.

The professionals who work in the care management program are called Care Managers. All Care Managers are nurses or social workers. They are part of a team made up of many different health care professionals and support staff.

A member of our care management team will call you to decide if care management can help you with your medical needs. He or she will ask questions to learn more about your health and lifestyle.

Once you are enrolled in care management, a Care Manager will work with you one-on-one. Your Care Manager will contact you by phone to learn about your health condition. He or she will talk about your health management priorities and help you set goals to improve your health. Your Care Manager will work with you on the steps to take to meet those goals.

A member of your care management team can also meet with you face-to-face several times a year. Your Care Manager will work directly with your primary care provider (PCP) and other providers to help coordinate your care. Your Care Manager will give you information on local resources that may also be able to help you. He or she can also help arrange transportation to your appointments.

To learn more, call Member Services. The phone number is on your member ID card. Member Services will connect you with a Care Manager.

For information about extra benefits Molina offers for members enrolled in Care Management, check out the Your Extra Benefits information mailed with your new member materials.

Behavioral Health Services

Mental health and substance use disorder treatment services are available. These services include:

- Diagnostic Evaluation and Assessment
- Psychological Testing
- Psychotherapy and Counseling
- Crisis Intervention
- Mental Health Services including Therapeutic Behavioral Service, Psychosocial Rehabilitation, Community Psychiatric Supportive Treatment, Assertive Community Treatment for Adults, and Intensive Home-Based Treatment for Children/Adolescents
- Substance Use Disorder Treatment Services including Case Management, Peer Recovery Support, Intensive Outpatient, Partial Hospitalization, Residential Treatment, and Withdrawal Management
- Medication-Assisted Treatment for Addiction (MAT)
- Opioid Treatment Program Services, which include dispensing of medication for persons diagnosed with opioid use disorder using any of three FDA-approved MAT medications: methadone, buprenorphine, and naltrexone
- Medical Services
- Behavioral Health Nursing Services

What to do if you are having a problem:
If you need mental health and/or substance use disorder treatment services, call Member Services at (800) 642-4168 (TTY for the hearing impaired: (800) 750-0750 or 711) or find a provider in the Provider Directory at MolinaProviderDirectory.com/OH.

You can see a provider that is part of our behavioral health network. You don't need a referral to see a doctor. You can pick or change your behavioral health provider at any time.

If you have a Care Manager, he or she can help you get the services you need and provide a list of covered services.

Call Member Services if you need help or are not sure what to do for:

- Sadness that does not get better
- Feeling hopeless and/or helpless
- Guilt
- Worthlessness
- Difficulty sleeping
- Poor appetite or weight loss
- Loss of interest

Emergency Behavioral Health Services

A behavioral health emergency is a mental health condition that may cause extreme harm or death. A behavioral health emergency might include:

- Injuring yourself by accident or on purpose
- Considering hurting yourself or others
- Unusual behavior that keeps you from carrying out daily life

If you have an emergency, go to the closest emergency room or call 911 right away. If you go to the emergency room, let your primary care provider (PCP) know as soon as you can.

If you have a behavioral health emergency and can't get to an approved provider, do the following:

- Go to the closest hospital or facility
- Call Member Services
- Call your doctor and follow-up within 24 to 48 hours

OhioRISE

The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) program is a managed care program for youth with behavioral health needs. OhioRISE aims to expand access to in-home and community-based services to ensure OhioRISE members and families have the tools they need to direct their interactions with multiple systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others.

An individual who is enrolled in the **OhioRISE** program will also keep their managed care enrollment (for example, your Molina Healthcare membership) for the physical health benefit.

OhioRISE Eligibility:

- Enrolled in Ohio Medicaid
- Under the age of 21
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment

OhioRISE Services:

In addition to the behavioral health services already available through Medicaid, OhioRISE offers the following services:

- Care Coordination determined by the CANS assessment
    - Your managed care organization will also be included in your care management.
- Intensive Home-Based Treatment (IHBT)
- Mobile Response and Stabilization Service (MRSS)
- Behavioral Health Respite
- Wraparound supports
- Psychiatric Residential Treatment Facility (PRTF): Available January 2023

For more information on **OhioRISE** services please contact Aetna Better Health of Ohio member services at (833) 711-0773.

Healthchek

Healthchek is Ohio's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for members under the age of 21. These exams make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

Healthchek covers medical, vision, dental, hearing, nutritional, developmental, behavioral health exams, and other care to treat physical, behavioral, or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization

Healthchek is available at no cost to members and include:

- Preventive check-ups for newborns, infants, children, teens, and young adults under the age of 21.
- Healthchek screenings:
    - Medical exams (physical and development screenings)
    - Vision exams
    - Dental exams
    - Hearing exams
    - Nutrition checks

    - Developmental exams
    - Lead testing
- Laboratory tests (age and gender appropriate exams)
- Immunizations
- Medically necessary follow-up care to treat health problems or issues found during a screening. This could include, but is not limited to:
    - Visits with a primary care provider, specialist, dentist, optometrist and other Molina Healthcare providers to diagnose and treat problems or issues
    - Inpatient or outpatient hospital care
    - Clinic visits
    - Prescription drugs
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early. That way your provider can treat them, or make a referral to a specialist for treatment, before the problem gets more serious. *Remember: Some services may require a referral from your primary care provider (PCP) or prior authorization by Molina Healthcare*. For some EPSDT items or services, your provider may ask for prior authorization for Molina Healthcare to cover things that have limits or are not covered for members over the age of 20. Please see page(s) 15 to 25 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 who have special health care needs. Please see page(s) 28 to 29 to learn more about the care management services offered by Molina Healthcare.

You can get Healthchek services by calling your PCP or dental provider and making an appointment. Be sure to say that you want to schedule a Healthchek appointment.

If you have any questions, or need help, call Member Services. We can help you:

- Access care.
- Learn what services are covered.
- Find a provider.
- Schedule transportation.
- Understand which services require prior approval.
- Make an appointment.

Member Services can also help you get a referral for:

- Women, Infants, and Children (WIC)
- Help Me Grow
- Bureau for Children with Medical Handicaps (BCMH)

- Headstart
- Other community services like food and heating assistance

Pregnancy and Newborn Care

If you think you are pregnant, see your primary care provider (PCP). If you want to avoid pregnancy, ask your PCP about family planning options.

If you are pregnant or have a baby:
If you are pregnant, you must call Member Services to let Molina know. You must also call us when your baby is born. We will send you a new ID card for your baby.

If you are pregnant, you must also tell your county caseworker at the County Department of Job and Family Services to get all the information and support you need for a healthy pregnancy.

When you are pregnant, your PCP will want you to see an OB/GYN. You don't need a referral to see an OB/GYN. You can find an OB/GYN in the Provider Directory at MolinaProviderDirectory.com/OH. If you need help, call Member Services.

Your newborn baby is covered by your Molina Medicaid plan until the end of the month he or she turns 1 year old. To continue coverage, you must enroll your new baby in Molina Healthcare. To enroll your baby in Molina Healthcare, you must call your county caseworker as soon as possible after delivery. If you have any questions about enrolling your new baby in Molina Healthcare, call Member Services.

Gift card rewards for you and baby!
You can earn gift card rewards just for seeing your doctor! Check out the Your Extra Benefits information mailed with your new member materials for more information about pregnancy and parent benefits. You can learn more online at MolinaHealthcare.com/OHMedicaidPregnancyRewards.

Telehealth

Telehealth is the direct delivery of health care using audio and/or video. Instead of coming into the provider's office for your appointment, you stay at your home or office and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost to use telehealth and telehealth removes the stress of needing transportation services.

You can see medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as for prescribing medication(s).

Check with your providers to see if they offer telehealth.

Virtual urgent care with Teladoc

With Teladoc, you can make a phone call or video chat anytime, anywhere! Adult* Molina members get 24/7 access to virtual urgent care with Teladoc.

Ask Teladoc doctors about urgent care conditions such as colds & flu, sore throat, sinuses, rashes, and more. If needed, doctors can send a prescription to your local pharmacy.

Get virtual care through Teladoc:

- Online: Teladoc.com/Molina-OH
- By phone: 1-800-Teladoc (1-800-835-2362)
- On your smartphone: Download the Teladoc app

**Members 19 and older are eligible for Teladoc services, except Children with Special Health Care Needs who become eligible at age 21.*

COVID-19 Testing and Vaccinations

Molina Healthcare will cover all Medicaid-covered COVID-19 testing, treatment, and vaccinations at no cost to you.

Molina Healthcare can assist you in finding a testing or vaccination location in your community. They also can help with scheduling and transportation to the appointment. Contact your plan at MyMolina.com or call the Molina Healthcare 24-hour Nurse Advice Line by phone at: (888) 275-8750 or TTY 711.

The Ohio Department of Health provides regular vaccination updates on the eligibility phases at: https://coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program.

How to Find COVID-19 Testing Locations
COVID-19 testing locations can be found online at: https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers.

How to Find COVID-19 Vaccine Providers
The Ohio Department of Health (ODH) has developed a search tool for Ohioans to use to find a vaccine provider. The directory is searchable by county and ZIP code and displays providers currently receiving shipments of COVID-19 vaccines. You can get information and vaccination locations at https://vaccine.coronavirus.ohio.gov/ or by calling the Ohio Department of Health toll free at 833-427-5634.

Specialty Care and Referrals

If you need special care that your PCP cannot give, he or she will refer you to a specialist. Getting a referral from your PCP is not required to see a specialist, but it ensures all your providers know your health care goals and plans.

Ask your PCP if you don't know how referrals work. If you think a specialist does not meet your needs, ask your PCP for help.

If Molina Healthcare's network does not include a specialist who can give you the care you need, we will help you get care from a specialist outside the network. See the next section to learn more about seeing out-of-network providers.

Emergency Services

What is an emergency?
Emergency services are for a medical problem that must be treated right away by a provider. We cover care for emergencies both in and out of the county where you live. Some examples of when emergency services are needed include:

- Miscarriage/pregnancy with vaginal bleeding
- Seizures or convulsions
- Unusual or excessive bleeding
- Unconsciousness
- Overdose/poisoning
- Severe burns
- Broken bones
- Chest pain
- Difficulty breathing

How to Get Emergency Care
An emergency needs attention right away. You do not have to contact Molina Healthcare before you get emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate care setting. You can get emergency care 24 hours a day, 7 days a week.

If you are not sure if you need to go to the ER, call your primary care provider (PCP), or the Molina Healthcare 24-hour Nurse Advice Line at (888) 275-8750 (Español (866) 648-3537) or TTY at (866) 735-2929. Your PCP or the 24-hour Nurse Advice Line can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Tell them that you are a member of Molina Healthcare and show them your Molina Healthcare member ID card.
- If the provider who treats your emergency, thinks you need other medical care to treat the problem that caused your emergency, the provider must call Molina Healthcare.
- After an emergency room visit, contact your PCP to make an appointment for follow-up care. Do not go to the emergency room for follow-up care.
- If the emergency room doctor says that you don't have to stay but you still stay, you may have to pay.
- If the hospital has you stay, make sure that Molina Healthcare is called within 24 hours.

If you don't have an emergency, you do not need to go to the ER. Call your PCP. If you need non-emergency care after normal business hours, you can visit an urgent care center or walk-in clinic.

You can find locations to get urgent care in the Provider Directory. If you need help finding one, you can call Member Services at (800) 642-4168 (TTY (800) 750-0750 or 711). You may also visit our website at MolinaProviderDirectory.com/OH.

Post-Stabilization Care

After your visit to the ER, you should call your doctor as soon as you can. Your doctor will help you get any follow-up care you need. These services are called post-stabilization care. They keep your condition stable. You do not need approval for these services. You can also call Member Services for help.

You may have received care from out-of-network providers during your emergency. If you did, we will try to get network providers to take over your care as soon as possible.

After-Hours Care and Urgent Care

Urgent care, also called non-emergency care, is when you need care right away, but you are not in danger of lasting harm or losing your life. Some examples include:

- Illness or injury
- Sore throat or cough
- Flu
- Migraine or headache
- Ear aches or ear infections
- Minor accidents or falls

If you need urgent care, call your PCP to request an appointment.

There may be times when your provider cannot see you right away. There may not be an appointment available or your provider's office may be closed. When you need care after your provider's office is closed, this is called after-hours care.

If you need after-hours care or your provider cannot schedule you an appointment right away, you can take steps to stop your injury or illness from getting worse.

1. Call your primary care provider (PCP) for advice. If you can't get an appointment, ask your PCP what to do next. Even if your provider's office is closed, someone may answer the phone. You can also leave a message at any time.

2. If you cannot reach your provider's office, Molina Healthcare offers other options to get care:
    - You can get virtual care with Teladoc. Adult members can get care online or by phone at no cost. No appointment is needed. Visit MolinaHealthcare.com/OHMedicaidVirtual to learn more.

    - You can call Molina Healthcare's 24-hour Nurse Advice Line. Registered nurses are always available to answer questions about your health. Call the 24-hour Nurse Advice Line at (888) 275-8750 or (866) 648-3537 (Español). For hearing impaired, call TTY (866) 735-2929.

3. Go to a network drop-in clinic or a network urgent care center listed in the Provider Directory. After you visit an urgent care center, always call your PCP to schedule follow-up care.

Hospital Services

You must have prior approval to get inpatient hospital services, except in the case of an emergency or urgent care services.

If you get services in a hospital or you are admitted to the hospital for emergency or urgent care services outside of Molina Healthcare's coverage area, your hospital stay will be covered. This happens even if you do not have prior approval.

Medical/Surgical Services

You can find covered inpatient services in the Covered Services List on page 21. We cover some additional inpatient services in a network hospital or rehabilitation facility, when the services are generally and customarily provided by acute care general hospitals or rehabilitation facilities inside our service area. They are:

- Anesthesia
- Blood, blood products and their administration, blood storage (including the services and supplies of a blood bank)
- Mastectomies (removal of breast) and lymph node dissections
- Medical social services and discharge planning
- Radioactive materials used for therapeutic purposes
- Respiratory therapy

Stop Smoking Program

Molina Healthcare's stop smoking program is for members who are ready to quit smoking. This program is available at no cost to you. You get:

- One-on-one counseling
- Educational materials
- A toll-free quit line to call at any time for help between scheduled calls at 1-800-QUIT-NOW (1-800-784-8669)
- Appropriate stop-smoking aids, such as nicotine replacement therapy, based on what you and your provider decide is right for you

Pharmacy Benefits Covered by Molina Healthcare

Prescription Drugs

Managed Care Organization (MCO) members will use Gainwell to process prescription claims and will need to refer to the Gainwell member handbook in appendix A of this handbook for assistance.

To contact Gainwell about your pharmacy benefits, call (833) 491-0344. The Pharmacy Benefit phone number is also listed on your Molina member ID card.

To find a pharmacy near you, visit spbm.medicaid.ohio.gov.

Coordinated Services Program

We want to make sure you get safe, quality health care services. Certain prescription drugs are controlled because there are many safety risks. The Coordinated Services Program (CSP) helps some members who visit multiple providers and/or pharmacies for certain prescription drugs.

If you are enrolled in the program, you will get a letter from Molina Healthcare letting you know. After you are enrolled, you will get a new member ID card in the mail. Your ID card will list your designated pharmacy and designated prescriber, if assigned. You must fill all of your prescription drugs at your designated pharmacy, except in emergency situations. You must see your designated prescriber for certain prescription drugs. You should talk with your primary care provider (PCP) before getting any medical services.

You may ask to change your designated pharmacy or prescriber, if your designated pharmacy or prescriber:

- Moves
- Closes
- Is no longer in our network
- Chooses not to provide some services

You may also ask to change your designated pharmacy or prescriber if you:

- Move
- Get an injury or illness that makes you unable to follow the program
- Transfer from another Medicaid plan to Molina Healthcare, and your designated pharmacy or prescriber is not part of the Molina Healthcare network

To ask for these changes, call the Pharmacy Benefit phone number or call Molina Healthcare Member Services. The phone number is on your Molina member ID card. You can also call your Molina care manager. All requests will be reviewed. If your request to change your designated pharmacy or prescriber is approved, you will get a new program ID card. If your request is not approved, you will stay with your current designated pharmacy or prescriber.

The minimum enrollment period for the program is 24 calendar months. If you are selected for Molina Healthcare's program, you will get additional information about the program. You will also get information on your state hearing rights.

In an emergency situation, Gainwell or Molina Healthcare must give approval for you to use a different pharmacy or prescriber for certain prescription drugs. Examples of an emergency

situation include a pharmacy being closed because of a weather emergency or a prescriber's office being closed on the weekend. You, or a pharmacy, can call Molina Healthcare at (800) 642-4168 (TTY 711) from 7 a.m. to 8 p.m. For after-hour emergencies, call Gainwell at (833) 491-0344 or call Molina's 24-Hour Nurse Advice Line at (888) 275-8750 or (866) 648-3537 (Español) (TTY: (866) 735-2929).

Services Not Covered by Molina Healthcare

Services and Supplies Not Covered by Medicaid

Molina Healthcare will not pay for services or supplies received that are not covered by Medicaid:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

Molina Healthcare will not pay for services received outside the U.S.

If you have a question about whether a service is covered, please call Member Services at (800) 642-4168 (TTY (800) 750-0750 or 711) Monday through Friday, 7 a.m. to 8 p.m.

Services Not Covered by Molina Healthcare unless Medically Necessary

Molina Healthcare regulations and conduct a medical necessity review if needed.

Molina Healthcare will not pay for the following services that are not covered by Medicaid **unless determined medically necessary:**

- Abortions except in the case of a reported rape, incest or save the life of the mother
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Plastic or cosmetic surgery
- Services for the treatment of obesity
- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or cannot legally consent to the procedure

How to Contact Molina Healthcare

Member Services

Molina Healthcare Member Services is here to answer questions you have about your Molina Medicaid membership.

You can call Member Services at (800) 642-4168 (TTY (800) 750-0750 or 711) from 7 a.m. to 8 p.m., Monday through Friday. You can also learn more about your Molina Healthcare covered benefits and services at MolinaHealthcare.com.

Member Services representatives can help you:

- Understand your covered benefits.
- Update your contact information.
- Ask for a new ID card.
- Schedule transportation.
- Pick or change your Primary Care Provider (PCP).
- Find a network provider or pharmacy near you.
- Check if prior approval (prior authorization) is needed for a service or drug.
- Find prenatal resources if you are pregnant.
- Make an appointment with your PCP, OB/GYN or other providers.
- Start prenatal or infant well visits.
- Get information in your primary language.
- File a complaint about your plan, a provider, transportation services, or discrimination.

If you are pregnant or if there is a change to your demographic information, you must call Member Services right away to tell us.

Member Services Holiday Closures

The Molina Healthcare office is closed on the following days:

- New Year's Day
- Martin Luther King Jr. Holiday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve Day – Open 7 a.m. to Noon only
- Christmas Day
- New Year's Eve Day – Open 7 a.m. to Noon only

A holiday that falls on a Saturday is observed on the Friday before. A holiday that falls on a Sunday is observed the Monday after.

Interpreter Services

If you need to speak in a language other than English, we can get an interpreter to talk to you. An interpreter can help you:

- Make an appointment
- File a complaint, grievance or appeal
- Learn about the benefits of your health plan

If you need an interpreter, call Member Services. This service is provided at no cost to you.

If you need help speaking to your provider in your own language, call your provider's office. They can get an interpreter to help you talk to your provider.

24-hour Nurse Advice Line

It's not always easy to know how to treat a health problem. You can call Molina Healthcare's 24-Hour Nurse Advice Line at any time, 7 days a week. Our registered nurses will help you understand and manage your health and wellness.

The Nurse Advice Line can help you:

- Care for yourself at home.
- Make an appointment with your provider.
- Find urgent care close to home.
- Call 9-1-1 or locate a nearby emergency department.

Our registered nurses are always ready to answer questions about:

- Where to go for the right care.
- How to find urgent care clinics or hospitals in your area.
- Prenatal care for pregnancy.
- Postpartum care after childbirth.
- Your new baby or child's health.
- Medical conditions like diabetes or heart disease.
- Accidents and injuries.
- Drugs your provider prescribed for you.

Call with your questions any time, day or night:
English: (888) 275-8750
Español: (866) 648-3537
TTY: 711

Tell Us What You Think!

Molina Healthcare makes every effort to give you and your family the best care. We do many studies throughout the year to find ways to improve. We take steps to bring you higher quality care and better service. This process is called "quality improvement."

If you get a survey in the mail that asks for your feedback on your health plan and providers, please be sure to take it. Your answers help us learn how to serve you better. You can call Member Services at any time if you have suggestions for us.

Types of Care and How Soon to Get Care

The chart below describes different types of care you might need. It also explains how to get each type of care, and how long you may wait to get care.

Appointment Guidelines

Type of Care Needed	Where To Go and Whom To Call	How Long You May Wait to Get Care
Emergency These are medical problems you think are so serious they must be treated right away. For more information, go to page 34.	**Call 911** or go to the nearest emergency department. 911 is the local emergency telephone system available 24 hours a day, 7 days a week. **Poison Control Center (800) 222-1222**	You should receive emergency care **immediately.**
Urgent Care and Non-emergency This is when you need care right away, but you are not in danger of lasting harm or losing your life. For more information, go to page 36.	Call your PCP to request an appointment. You can also visit a network urgent care center or drop-in health clinic, like a MinuteClinic® inside some CVS Pharmacy® locations. Adults can get virtual care with Teladoc over the phone, video, or mobile app. See page 33 for more information. View the Provider Directory or call Member Services to find a network urgent care center or drop-in health clinic near you.	If you go to an urgent care center, you should receive care **as soon as possible.** When you get care may depend on the doctors available and how severe your condition is. For non-emergency care from your PCP or other provider, you should receive care by the **end of the next work day.** For virtual care with Teladoc, you should receive care within 10 minutes.
Routine care such as a physical exam, well visit or immunizations.	Call your PCP to request an appointment.	You should receive care within **4 weeks.**

Family planning and women's health services - Health screenings Prenatal care - Postpartum care Family planning methods (birth control pills, patch, ring, IUD, injections, implants) - Supplies (condom, foam, film, diaphragm, cap) - Treatment for sexually transmitted infections (STIs)	You do not need a referral to receive women's health or family planning services. You can go directly to your PCP, an OB/GYN listed in the Provider Directory, Certified Nurse Midwife, or Qualified Family Planning Provider.	If you are pregnant or believe you may be pregnant, you should have your first visit within **2 weeks.** You will receive routine pregnancy care within **6 weeks.** You should receive care for other family planning services within **8 weeks.**
Specialist appointments For more information, go to page 34.	Think about asking your PCP first. Although it's not required, your PCP may give you a referral to a specialist.	You should receive care within **8 weeks.**
Behavioral health services (Mental health and substance use disorder treatment services) For more information, go to page 29.	Call a Community Mental Health Center or Ohio Department of Mental Health and Addiction Services (MHAS) facility. If you need help finding a mental health facility or provider near you, visit mha.ohio.gov or call Member Services.	In a non-life threatening emergency, you should receive care within **6 hours.** You should receive urgent care within **48 hours.** You should receive routine care within **10 business days**. You should receive routine follow-up care within **30 days.**

Your Member Rights and Responsibilities

These rights and responsibilities are available online at MolinaHealthcare.com/OHMedicaidRights.

Your Membership Rights

As a member of Molina Healthcare you have the following rights:

- To receive all information and services that Molina Healthcare must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.
- To participate with providers in making decisions relating to your health care.
- To be able to take part in decisions about your health care as long as the decisions are in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To say "yes" or "no" to having any information about you given out unless Molina Healthcare must by law.
- To say no to treatment or therapy. If you say no, the provider or Molina Healthcare must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing. See page 52 of this handbook to learn more.
- To get help free of charge from Molina Healthcare and its providers if you do not speak English or need help in understanding information.
- To get all written member information from the Molina Healthcare:
  - at no cost to you.
  - in the prevalent non-English languages of members in the Molina Healthcare: service area.

- in other ways, to help with the special needs of members who may have trouble reading the information for any reason.

- To get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse their care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See page 48 to learn more about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP in the Molina Healthcare's network at least monthly. Molina Healthcare must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that the Molina Healthcare, the Molina Healthcare providers or the Ohio Department of Medicaid will not hold this against you.
- To know that the Molina Healthcare must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider in the Molina Healthcare network for covered woman's health services.
- To get a second opinion from a qualified provider in the Molina Healthcare 's network. If a qualified provider is not able to see you, Molina Healthcare must set up a visit with a provider not in our network.
- To get information about Molina Healthcare from us.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

The Ohio Department of Medicaid
Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

E-mail: ODM_EmployeeRelations@medicaid.ohio.gov
Fax: (614)644-1434

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
Ph: (312) 886-2359 TTY (312) 353-5693

You also have the right to:

- Voice complaints about Molina Healthcare.
- Voice complaints about the care you were given.
- Request appeals for denied prior approval requests.
- Get information about Molina Healthcare.
- Get information about covered benefits.
- Get information about network providers.
- Openly discuss your treatment options in a way that is easy to understand. You have this right no matter the cost or benefit coverage.
- Get information about your member rights and responsibilities.
- Make suggestions about Molina Healthcare's member rights and responsibilities.
- Get a second opinion from a qualified network provider. Molina Healthcare must set up a visit with a non-network provider at no cost to you if a qualified network provider is not able to see you.

Member Responsibilities

As a member of Molina Healthcare, you have the responsibility to:

- Always carry your Molina Healthcare ID card. Do not let anyone else use your ID card.
- Keep appointments. Be on time.
- If you need transportation, call Molina Healthcare at least 2 business days ahead of time whenever possible.
- Call your provider 24 hours in advance if you will be late or if you cannot keep your appointment.
- Share health information (to the extent possible) with Molina Healthcare and your providers. Do this so you get the right care.
- Understand your health conditions (to the degree possible). Be active in decisions about your health care.
- Work with your provider to develop treatment goals. Follow the care plan that you and your provider have developed.
- Make sure you take the medications prescribed for you by your doctor.
- See your doctor in the office within 30 days of being discharged from a hospital. Remember to bring the Discharge Summary you were given.
- During office appointments, review your medications to keep the list current.
- Ask questions if you do not understand your benefits.
- Call Molina Healthcare within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.

- Tell Molina Healthcare if you would like to change your primary care provider (PCP). Molina Healthcare will make sure the PCP you pick is in our network and taking new patients.
- Tell Molina Healthcare and your county caseworker if you change your name, address or telephone number.
- Tell Molina Healthcare if you have any changes that could affect your Medicaid eligibility.
- Tell Molina Healthcare and your health care providers if you or any of the members of your family have other health insurance coverage.
- Report any fraud or wrongdoing to Molina Healthcare or the proper authorities.

Member Privacy

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

Why does Molina use or share your Protected Health Information (PHI)?

- To provide for your treatment.
- To pay for your health care.
- To review the quality of the care you get.
- To tell you about your choices for care.
- To run our health plan.
- To share PHI as required or permitted by law.

The above is only a summary. Our Notice of Privacy Practices gives more information about how we use and share our members' PHI. You may find our full Notice of Privacy Practices on our website at MolinaHealthcare.com/OHMedicaidPrivacy.

Fraud, Waste and Abuse

Molina Healthcare's Fraud, Waste and Abuse Plan benefits Molina Healthcare, its employees, members, providers, payers and regulators by increasing efficiency, reducing waste, and improving the quality of services. Molina Healthcare takes the prevention, detection, and investigation of fraud, waste and abuse seriously, and complies with state and federal laws. Molina Healthcare investigates all suspected cases of fraud, waste and abuse and promptly reports to government agencies when appropriate. Molina Healthcare takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or termination of membership.

You can report potential fraud, waste and abuse without giving us your name.

To report suspected Medicaid fraud, contact Molina Healthcare AlertLine toll-free at (866) 606-3889.

Or

Complete a report form online at https://www.molinahealthcare.alertline.com.

Definitions:
"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for them or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

"Waste" means health care spending that can be eliminated without reducing the quality of care. Quality Waste includes overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid/Medicare programs.

Here are some ways you can help stop fraud:

- Don't give your Molina Healthcare ID card, Medical ID Card, or ID number to anyone other than a health care provider, a clinic, or hospital. Only give your ID card when receiving care.
- Never let anyone borrow your Molina Healthcare ID card.
- Never sign a blank insurance form or timesheet.
- Be careful about giving out your social security number.

Advance Directives

You Have the Right:
Using Advance Directives to State Your Wishes about Your Medical Care

People often worry about the medical care they would get if they became too sick to make their wishes known.

Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.

You can state your medical care wishes in writing while you are healthy and able to choose. Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

This document explains your rights under Ohio law to accept or refuse medical care. The document also explains how you can state your wishes about the care you would want if you could not choose for yourself.

This document does not contain legal advice, but will help you understand your rights under the law.

What are my rights to choose my medical care?
You have the right to choose your own medical care. If you do not want a certain type of care, you have the right to tell your doctor you do not want it.

What if I am too sick to decide? What if I cannot make my wishes known?
Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you are able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

What kinds of forms are there?
Under Ohio law, there are four different forms, or advance directives, you can use: a Living Will, a Do Not Resuscitate (DNR) Order, a Health Care Power of Attorney (also known as a Durable Power of Attorney for Health Care) and a Declaration for Mental Health Treatment. You fill out an advance directive while you are able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

Do I have to fill out an advance directive before I get medical care?
No. No one can make you fill out an advance directive. You decide if you want to fill one out.

Who can fill out an advance directive?
Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

Do I need a lawyer?
No, you do not need a lawyer to fill out an advance directive.

Do the people giving me medical care have to follow my wishes?
Yes, if your wishes follow state law. However, a person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

Living Will
A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:
» in a coma that is not expected to end,

- OR –

» beyond medical help with no hope of getting better and can't make your wishes known,

- OR –

» expected to die and are not able to make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes.

Only you can change or cancel your Living Will. You can do so at any time.

Do Not Resuscitate Order
A Do Not Resuscitate (DNR) Order is an order written by a doctor or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, that instructs health care providers not to do cardiopulmonary resuscitation (CPR). In Ohio, there are two types of DNR Orders: (1) DNR Comfort Care, and (2) DNR Comfort Care – Arrest. You should talk to your doctor about DNR options.

Health Care Power of Attorney
A Health Care Power of Attorney is different from other types of powers of attorney. This document talks only about a Health Care Power of Attorney, not about other types of powers of attorney.

A Health Care Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you cannot act for yourself. This could be for a short time period or for a long time period.

Who should I choose?
You can choose any adult relative or friend whom you trust to act for you when you cannot act for yourself.

Be sure to talk with the person about what you want. Then write down what medical care you do or do not want. You should also talk to your doctor about what you want. The person you choose must follow your wishes.

When does my Health Care Power of Attorney take effect? The form takes effect only when you can't choose your care for yourself. The form allows your relative or friend to stop life support only in the following circumstances:
» if you are in a coma that is not expected to end,

- OR –

» if you are expected to die.

Declaration for Mental Health Treatment
A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows you, while capable,

to appoint a representative to make decisions on your behalf when you lack the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment.

For example, you can indicate medication and treatment preferences, and preferences concerning admission/ retention in a facility.

What is the difference between a Health Care Power of Attorney and a Living Will?
Your Living Will explains, in writing, your wishes about the use of life-support methods if you are unable to make your wishes known. Your Health Care Power of Attorney lets you choose someone to carry out your wishes for medical care when you cannot act for yourself.

If I have a Health Care Power of Attorney, do I need a Living Will, too?
You may want both. Each addresses different parts of your medical care.

Can I change my advance directives?
Yes, you can change your advance directives whenever you want. It is a good idea to look over your advance directives from time to time to make sure they still say what you want and that they cover all areas.

If I don't have an advance directive, who chooses my medical care when I can't?
Ohio law allows your next-of-kin to choose your medical care if you are expected to die and cannot act for yourself.

Where do I get advance directive forms?
Many of the people and places that give you medical care have advance directive forms. You may also be able to get these forms from CaringInfo at https://www.caringinfo.org/planning/advance-directives/by-state/ohio/.

What do I do with my forms after filling them out?
You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Health Care Power of Attorney, give that person a copy. Put a copy with your personal papers.

You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends about what you have done. Do not just put these forms away and forget about them.

Organ and Tissue Donation
Ohioans can choose whether they would like their organs and tissues to be donated to others in the event of their death. By making their preference known, they can ensure that their wishes will be carried out immediately and that their families and loved ones will not have the burden of making this decision at an already difficult time. Some examples of organs that can be donated are the heart, lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

There are two ways to register to become an organ and tissue donor:

1. You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State I.D. Card,

- OR –

2. You may register online for organ donation through the Ohio Donor Registry website: www.donatelifeohio.org

Appeals and Grievances

Filing a Grievance or Appeal

If you are unhappy with Molina Healthcare or our providers, or do not agree with a decision we made, contact us as soon as possible. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know. We need your written consent for someone else to file a grievance or appeal on your behalf. Molina Healthcare wants to help.

You may file a grievance or an appeal on behalf of a member who is younger than age 18 without written consent, if you belong to the member's assistance group.

To contact us, you can:

- Contact Member Services Department at (800) 642-4168, TTY/TDD: 711 or (800) 750-0750,
- Fill out the form in your member handbook,
- Call Member Services Department to ask for a printed copy
- Visit our website at MolinaHealthcare.com,
- Write a letter telling us what you are unhappy about. Please include your first and last name, the number from the front of your Molina Healthcare member ID card, your address and your telephone number. You should also send any information that helps explain your problem.

You can find the form on page 65.

Mail the form or your letter to:
Molina Healthcare of Ohio, Inc.
P.O. Box 349020
Columbus, OH 43234-9020

Molina Healthcare will send you something in writing if we decide to:

- deny a request to cover a service for you.
- reduce, suspend, or stop services before you receive all of the services that were approved; or
- deny payment for a service you received that is not covered by Molina Healthcare

We will also send you something in writing if we did not:

- decide on whether to cover a service requested for you, or
- give you an answer to something you told us you were unhappy about.

Appeals

If you do not agree with the decision or action listed in the letter, you can contact us **within 60 calendar** days to ask that we change our decision or action. This is called an appeal. The 60-calendar day period begins on the day after the mailing date on the letter. If we have decided to reduce, suspend, or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

Unless we tell you a different date, we must give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action because of your appeal, we will notify you of your right to request a state hearing. **You may only request a state hearing after you have gone through Molina Healthcare's appeal process.**

Grievances

If you contact us because you are unhappy with Molina Healthcare or our providers, this is called a **grievance**. Molina Healthcare will give you an answer to your grievance by phone, or by mail if we can't reach you by phone. We will give you an answer within the following time frames:

- two working days for grievances about not being able to get medical care
- thirty calendar days for all other grievances except grievances about getting a bill for care you have received
- sixty calendar days for grievances about getting a bill for care you have received.

If we need more time to make a decision for either an appeal or a grievance, we will send you a letter telling you that we need to take up to 14 more calendar days. That letter will also explain why we need more time. If you think we need more time to make a decision on your appeal or grievance, you can also ask us to take up to 14 calendar days.

You also have the right to file a complaint **at any time** by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-605-3040 or 1-800-324-8680
TTY: 1-800-292-3572

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215
1-800-686-1526

State Hearings

A state hearing is a meeting with you or someone you want to speak on your behalf, someone from the County Department of Job and Family Services, someone from Molina Healthcare, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think Molina Healthcare did not make the right decision and Molina Healthcare will explain the reasons for making our decision. The hearing officer will listen and then decide who is right based on the rules and the information given.

Molina Healthcare will notify you of your right to request a state hearing if:

- we do not change our decision or action because of your appeal
- a decision is made to propose enrollment or continue enrollment in the Coordinated Services Program (CSP)
- a decision is made to deny your request to change your CSP provider.

You may only request a state hearing after you have gone through Molina Healthcare's appeal process.

If you want a state hearing, you, or someone you want to speak on your behalf, must request a hearing **within 90 calendar days**. The 90-calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before all the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services. If we propose to enroll you in the Coordinated Services Program (CSP) and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

To request a hearing:

- you can sign and return the state hearing form to the address or fax number listed on the form,
- call the Bureau of State Hearings at (866) 635-3748,
- submit your request via e-mail at bsh@jfs.ohio.gov.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at (800) 589-5888.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, the MCO or the Bureau of State Hearings may decide that the health condition meets the criteria for an expedited decision. An expedited decision will be issued as quickly as needed but no later than three working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life, your health or your ability to attain, maintain, or regain maximum function.

Policies for Medicaid Membership

Estate Recovery

If you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payment that Medicaid pays to your managed care plan, even if the capitation payment is greater than the cost of the services you received. **Estate Recovery only happens after the death of the Medicaid recipient.**

Accidental Injury or Illness (Subrogation)

If you have to see a doctor for an injury or illness that was caused by another person or business, you must call Member Services to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store, another insurance company may have to pay for the care or services you received. When you call us give the name of the person at fault, their insurance company and the name(s) of any attorney(s) involved.

Other Health Insurance (Coordination of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is **very important** that you call Member Services and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent, you need to call Member Services. It is also important to tell Member Services and your county caseworker if you have lost health insurance that you previously reported. Not giving us this information can cause problems with getting care and with payment of medical bills.

Loss of Insurance Notice

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company. This notice says you no longer have insurance. Keep a copy of this notice for your records because you might be asked to provide a copy.

Medicaid Renewal and Loss of Medicaid Eligibility

It is important that you keep your appointments with the County Department of Job and Family Services (CDJFS). If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happened, Molina Healthcare would be told to stop your membership as a Medicaid member and you would no longer be covered by Molina Healthcare.

For questions about Medicaid eligibility:

- Call or visit your local CDJFS office or caseworker. They are your best resource because they are the ones who determine if you still qualify for Medicaid benefits. Find the number at http://www.jfs.ohio.gov/county/county_directory.pdf.
- Call the Medicaid Consumer Hotline at (800) 324-8680 or TTY 711. Call Monday to Friday, 7 a.m. to 8 p.m., or Saturdays 8 a.m. to 5 p.m.

Automatic Renewal of Molina Healthcare Membership

If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become a Molina Healthcare member again.

Ending Your Molina Healthcare Membership

As a member of a managed care organization (MCO), you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment month. The Ohio Department of Medicaid will send you something in the mail to tell you when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care organization to cover your health care services.

If you want to end your membership during the first three months of your membership or during the annual open enrollment month, you can call the Medicaid Hotline at (800) 324-8680; (TTY (800) 292-3572). You can also submit a request online to the Medicaid Hotline website at www.ohiomh.com. If you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care organization, your new managed care organization will send you information in the mail before your membership start date.

Choosing A New Plan

If you are thinking about ending your membership to change to another managed care organization (MCO), you should learn about your choices. Especially if you want to keep your current provider(s). Remember, each MCO has its own list of doctors and hospitals that are in the network. Each MCO also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a managed care organization you are thinking of joining or if you simply have questions about the MCO, you may either call the plan or call the Medicaid Hotline at (800) 324-8680; TTY (800) 292-3572. You can also find information about the MCOs in your area by visiting the Medicaid Hotline website at www.ohiomh.com

Just Cause Membership Terminations

Sometimes there may be a special reason that you need to end your membership with a plan. This is called a "just cause" membership termination. To ask for a just cause membership termination, you may first call Molina Healthcare and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a just cause termination if you have one of the following reasons:

1. You move and your current MCO is not available where you now live, and you need non-emergency medical care in your new area before your MCO membership ends.
2. Your current MCO does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time and the services are not are not all in the MCO's network.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider in the Molina Healthcare network.
5. You do have access to medically necessary Medicaid-covered services or do not have access to providers that are experienced in dealing with your special health care needs.

6. The PCP that you chose is no longer on your in the Molina Healthcare's network and that was the only in-network PCP who spoke your language and was located within a reasonable distance from you; or another plan has a PCP in their network that speaks your language that is located within a reasonable distance from you and will accept you as a patient.

7. If you think staying as a member in your current managed care plan is harmful to you and not in your best interest.

You may ask to end your membership for just cause by calling the Medicaid Hotline at (800) 324-8680; (TTY (800) 292-3572). The Ohio Department of Medicaid will review your request and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date your membership ends. If you live in a mandatory enrollment area, you will have to choose another plan unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to keep in mind if you end your membership
If you have followed any of the above steps to end your membership, remember:

- Continue to use Molina Healthcare doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- If you chose a new Managed Care Organization (MCO) and have not received a member ID card before the first day of the month when you are a member of the new plan, call the Molina Healthcare Member Services Department. If Molina Healthcare is unable to help you, call the Medicaid Hotline at (800) 324-8680; TTY (800) 292-3572.
- If you have chosen a new MCO and have any medical visits scheduled, call your new plan to be sure that these providers are in the new plan's provider network and that any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or x-ray scheduled and especially if you are pregnant.
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Optional Membership Terminations
You have the option not to be a member of a managed care organization (MCO) if:

- You are a member of a federally recognized Indian tribe, regardless of your age.
- You are an individual who receives home- and community-based waiver services through the Ohio Department of Developmental Disabilities.

If you believe that you or your child meet any of the above criteria and do not want to be a member of a managed care organization, you can call the Medicaid Hotline at (800) 324-8680 (TTY (800) 292-3572). If you meet the above criteria and does not want to be an MCO member, your MCO membership will be ended.

Exclusions – Individuals that are not permitted to join a Medicaid MCO:
You may not be allowed to join a Medicaid managed care organization (MCO) if you are:

- Dually eligible under both the Medicaid and Medicare programs:
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or some other kind of institution); or
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.
    * If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Organization. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Organization.

If you believe that you meet any of the above criteria and should not be a member of a Managed Care Organization, you must call the Medicaid Hotline at (800) 324-8680 (TTY (800) 292-3572). If you meet the above criteria, your MCO membership will be ended.

Can Molina Healthcare End My Membership?
Molina Healthcare may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended.

The reasons that Molina Healthcare can ask to end your membership are:

- For fraud or for misuse of your Molina Healthcare ID card
- For disruptive or uncooperative behavior to the extent that it affects the MCO's ability to provide services to you or other members.

Molina Healthcare provides services to our members because of a contract that Molina Healthcare has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid you can call or write to:

Ohio Department of Medicaid
Office of Managed Care
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
Phone: (800) 324-8680
TTY: (800) 292-3572

You can also visit the Ohio Department of Medicaid on the web at www.medicaid.ohio.gov

You can contact Molina Healthcare to get any other information you want including the structure and operation of Molina Healthcare and how we pay our providers. If you want to tell us about things you think we should change, call Member Services at (800) 642-4168 (TTY (800) 750-0750 or 711).

How Molina Healthcare Pays Providers for Your Care

Molina Healthcare contracts with providers in many ways.
Some Molina Healthcare providers are paid on a fee-for-service basis. This means they are paid each time they see you and for each service they perform. Other providers are paid a flat amount for each month a member is assigned to their care, whether or not they see the member.

Some providers may be offered rewards for offering excellent preventive care and monitoring the use of hospital services. Molina Healthcare does not reward providers or employees for denying medical coverage or services. Molina Healthcare also does not give bonuses to providers to give you less care. For more information about how providers are paid, please call Member Services.

Payment and Bills

Molina Healthcare members are not responsible for co-payments or other charges for covered medical services. If you get a bill from a plan provider for approved and covered services, call Member Services. Do not pay the bill until you have talked to us. We will help you with this matter.

If the statement does not list any patient responsibility, this means you have a statement, not a bill. The provider is just telling you that your insurance company has been billed for those services. These statements say at the top of the page that "this is not a bill." If you did not receive the services listed in the statement, please call Member Services right away.

You may have to pay for services that are not covered. You may also have to pay for services from providers who are not part of our network. If the services were an emergency, you don't have to pay. If you need help, call Member Services.

Glossary (Definitions)

Advance Directives – Written health care instructions for when an adult is not able to make his or her medical wishes known. This includes:

- Living Will
- Durable Power of Attorney for Medical Care
- Declaration for Mental Health Treatment
- Do Not Resuscitate Order

Appeal – A member's request for the Molina Healthcare plan to review an adverse benefit determination.

Behavioral Health – A term used for any mental health or substance use conditions.

Co-payment – A fixed amount a member pays for a covered health care service. Molina Healthcare members are not responsible for co-payments or other charges for covered medical services.

Coordinated Services Program (CSP) – If you are enrolled in the Coordinated Services Program, you must fill all of your prescription drugs at one pharmacy and you may also be limited to one prescriber for certain medications, except in emergency situations. If you are enrolled in the program, you will receive a program ID card that lists the pharmacy and prescriber where you must get your prescriptions.

Covered Services – Services and supplies covered by Molina Healthcare.

Durable Medical Equipment – Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Examples are wheelchairs, oxygen equipment, or crutches. Also known as home medical equipment.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For example, a miscarriage or difficulty breathing.

Emergency Medical Transportation – Transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care. For example, you might be taken to a hospital in an ambulance if you need emergency care.

Emergency Room Care – Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Emergency Services – Covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an

emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with the Molina Healthcare plan.

Excluded Services – Health services that the Molina Healthcare plan does not pay for or cover. You can find a list of services not covered by Molina Healthcare in this Handbook.

Fraud, Waste and Abuse –

- **Fraud:** An unfair or unlawful act that is done on purpose to illegally get something of worth.
- **Waste:** Practices that lead to unneeded cost and lower quality of care.
- **Abuse:** Provider and member practices that lead to unneeded cost to the Medicaid and/or Medicare programs. It may also lead to payment for services that do not meet professionally recognized standards for health care.

Generic Drug – A prescription drug that is approved by the government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper. It works just as well as the brand name drug.

Grievance – A member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

Habilitation Services and Devices – Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This may include physical and occupational therapy or other services for people with disabilities.

Health Insurance – A contract that requires your Molina Healthcare plan to pay some or all of your health care costs in exchange for a premium. Health insurance may also be called a "plan" or "policy."

Home Health Care – Services that include home health nursing, home health aide services and skilled therapies. These services usually do not include help with non-medical tasks, like cleaning or driving.

Hospice Services – A public agency, a private organization, or a subdivision of either, subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engaged in providing care to terminally ill individuals (5160-56-01(V)). Hospice services are a type of medical and social support care that helps relieve suffering, for the management of a person's terminal illness. Hospice care does not treat the person's illness.

Hospitalization – Care in a hospital that requires admission as an inpatient.. Hospitalization usually requires an overnight stay.

Hospital Outpatient Care – Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital. This is care in a hospital that usually does not require an overnight stay.

Managed Care Entity (MCE) – A health plan licensed by the state of Ohio to provide prepaid medical and hospital services to Medicaid eligible consumers.

Medicaid – A government program. It uses federal, state and local funds. It provides medical insurance for people of all ages within certain income limits.

Medically Necessary – Criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Member – A person who is eligible for Medicaid and who is enrolled in the Molina Healthcare plan.

Member Services – A department in our plan. Member Services answers questions about your plan, benefits and concerns.

Molina Healthcare – A managed care plan licensed by the state of Ohio to provide prepaid medical and hospital services to Medicaid-eligible consumers.

Network – The Molina Healthcare plan's contracted providers available to the Molina Healthcare plan's members.

Network Pharmacy – A pharmacy (drug store) that fills prescriptions for our members. They have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at a network pharmacy.

Network Provider (or Network, Participating Provider) – Any provider, group of providers, or entity that has a network provider contract with the Molina Healthcare plan in accordance with rule 5160-26-05 of the Administrative Code and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the Molina Healthcare plan's provider agreement or contract with ODM. We also call them "panel providers." They must be licensed or certified by Medicaid. They have agreed to work with our plan. They will not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services.

Out-of-Network (Non-participating Provider) – Any provider with an ODM provider agreement who does not contract with Molina Healthcare but delivers health care services to Molina Healthcare's members.

Physician Services – "Practitioner of physician services" are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners or physician assistants (5160-2-02(L)). For example, a physician might be a Medical Doctor (M.D.) or a Doctor of Osteopathic Medicine (D.O.).

Plan - "Managed care organization (MCO)" or "managed care plan (MCP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM (5160-26-01(S)).

Post-Stabilization Services – Covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R.422.113 to improve or resolve the member's condition. This is follow-up care you need after getting care for an emergency. This follow-up care makes sure you get better.

Preferred Drug List (PDL) – A list of prescription drugs covered by the plan. The plan picks the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Premium – "Premium" means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM (516026-01(NN)). You do not pay a premium as a Molina Healthcare member.

Prescription Drug Coverage – Drugs covered by the Single Pharmacy Benefit Manager (SPBM) that are dispensed to members for the use in a patient's resident, including a nursing facility or intermediate care facility for individuals with intellectual disabilities. You get pharmacy benefits through Gainwell.

Prescription Drugs - Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Preventive Health Care – Health care focused on finding and treating health problems to prevent disease or illness.

Primary Care Provider (or Primary Care Physician, PCP) – An individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Ohio Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Ohio Administrative Code contracting with Molina Healthcare to provide services as specified in rule 5160-26-03.1 of the Ohio Administrative Code. Your PCP helps you with most of your medical needs.

Prior Approval (Preauthorization) – A decision by the Molina Healthcare plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

Provider – A hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to Molina Healthcare's members. This includes hospitals, home health agencies, clinics and other places that give you health services, medical equipment, and long-term services and supports.

Provider Directory – A list of all the providers in the Molina Healthcare network. We call them network providers.

Rehabilitation Services and Devices – Specific tasks that must, in accordance with Title 47 of the Ohio Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel. These are health care services that help a person keep, get back, or improve skills and functioning for daily living. These services may be provided for skills or functioning that was lost or lessened because the person was sick, hurt, or disabled.

Referral – A request from a PCP for his or her patient to see another provider for care. You do not need a referral to see a provider.

Service Area – The geographic area where Molina Healthcare provides services.

Skilled Nursing Care – Specific tasks that must, in accordance with Chapter 4723 of the Ohio Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly. These services are performed or supervised by licensed nurses in your home or in a nursing home.

Specialist – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Telehealth (virtual care) – Care you get online, by mobile app, or over the phone. Medicaid members can see medical and behavioral health providers with telehealth for many illnesses and injuries. See page 33 to learn more about telehealth.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care. You can get this care from out-of-network providers when network providers are not available or you cannot get to them. It is also called "non-emergency care."

Grievance and Appeal Form

Member Grievance/Appeal Request Form

Instructions for filing a grievance/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit. (Do not send originals.)
3. If you have someone else submit on your behalf, you must give your consent below.
4. You may submit the completed form through one of the following ways
    a. Send to the address listed below,
    b. Fax to the fax number below, or
    c. Present your information in person. To do this, call us at the number listed below.

Molina Healthcare cannot promise that the way you submit this form to us is a secured method. For example, submitting this form via mail or fax may not be secure.

We will send a written acknowledgement letter of your request. It will be mailed to you within three (3) working days after the request is received.

Member's name: _____

Today's date: _____

Name of person requesting grievance/appeal, if other than the Member:

_____

Relationship to the member:_____

Member's ID #: _____

Daytime telephone #:_____

Specific issue(s):_____
Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed.

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature: _____

Date: _____

If you would like help with your request, we can help. We can help you in the language you speak or if you need other special support for hearing or seeing. You can call, write or fax us at:

Molina Healthcare of Ohio
Attn: Grievance & Appeal Department
P.O. Box 349020
Columbus, Ohio 43234-9020

Molina Healthcare Member Services: (800) 642-4168
Hearing Impaired TTY/Ohio Relay: (800) 750-0750 or 711
Fax Number: (866) 713-1891
Member Services (800) 642-4168, TTY/Ohio Relay Service (800) 750-0750 or 711

www.MolinaHealthcare.com

Appendix A: Gainwell Pharmacy Benefits Handbook

Ohio Single Pharmacy Benefit Manager (SPBM)

1 Member Handbook Contents

1.1 Corporate Identity

Gainwell Technologies is a company with over 50 years of proven experience, and a reputation for service excellence and unparalleled expertise. Gainwell does not operate under any other trade names or DBA. At Gainwell, everything we do focuses on people.

The mission at Gainwell is to empower clients through innovative technologies and solutions to deliver great health and human services outcomes.

You are now a member of our Single Pharmacy Benefits Manager (SPBM). Here at Gainwell, we believe you deserve quality pharmacy services and should receive the most up-to-date services that we can provide.

Online: https://spbm.medicaid.ohio.gov

Email: OH_MCD_PBM@gainwelltechnologies.com

If you suspect provider or consumer fraud, please contact our Fraud, Waste, and Abuse toll free tip line at 1-833-491-0344 (TTY 1-833-655-2437) and select the option to report Fraud, Waste, and Abuse concerns.

1.2 Available Services

Gainwell covers all Medicaid-covered, medically necessary prescription and over-the-counter (OTC) medications. We use a preferred drug list (PDL) which is a list of drugs we prefer your provider prescribe. We may require your prescriber to submit a prior authorization request, which is where your prescriber would provide us additional information explaining why a specific medication and/or a certain dose or quantity of medication may be required.

The below services are available to you to support any additional needs you may have:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in alternative formats including braille and large print.

1.2.1 Preferred Drug List

Gainwell uses a PDL which is a list of drugs we prefer your provider prescribes. You can find a copy of the PDL in the following locations:

- Under the Medicaid information tab at: https://spbm.medicaid.ohio.gov
- Logging in to your Gainwell Member Portal at: https://spbm.medicaid.ohio.gov
- The Ohio Department of Medicaid pharmacy website at: https://pharmacy.medicaid.ohio.gov/unified-pdl
- A paper copy can be requested by calling Member Services at 1-833-491-0344 (TTY 1-833-655-2437)

1.2.2 Prior Authorizations

Your prescriber may be required to submit a prior authorization request for certain medications. These requests will be sent by your prescriber through many different routes (phone, fax, mail, or web portal) to ensure a quick and efficient review of your medication. In these circumstances, your provider will send an authorization request to the Gainwell Pharmacy Services team, where they will complete a clinical review of the medication your provider is requesting. Gainwell Pharmacy Services team will work closely with your prescriber to provide the best clinical decision. You will receive a letter in the mail with the outcome of the decision made.

If you do not agree with the decision that is made by Gainwell, you will be sent detailed information on how you can appeal our decision.

You have the option to call Member Services toll free at 1-833-491-0344 (TTY 1-833-655-2437) to obtain information regarding the PDL, medications that may require prior authorization, or to ask any medication related questions you may have. The PDL and a list of medications that require prior authorization are available for you to access online at: https://spbm.medicaid.ohio.gov. It is important that you and/or your prescriber reference the

PDL and/or the list of medications that require prior authorizations each time you have questions, as these are documents that can change.

1.2.3 Pharmacy Utilization Management Strategies

The PDL will be used with each prior authorization review that is completed by the Gainwell Pharmacy Services team. When a prior authorization is required, Gainwell must approve the prescriber's request before you will be able to fill your medication at your preferred, in-network pharmacy. A prior authorization may be required if:

- A generic or pharmacy alternative drug is available.
- The requested drug can be misused/abused.
- Other medications must be tried first.
- Quantity limits for the requested medication have been exceeded.
- The medication your provider has prescribed is not included on the PDL.

The PDL usually includes multiple medication options for treating a particular condition. These different drugs are referred to as "alternative" drugs and are just as effective as other drugs with no additional side effects or health problems.

Specific reasons your prescriber may be required to submit a prior authorization request include:

Step Therapy – In some case, our plan requires you first try certain drugs to treat your medical condition.

Generic Substitution – This is where a pharmacy will be required to provide a generic drug in place of a brand-name drug when available. Generic drugs are just as safe and effective as brand name drugs and should be prescribed first.

Therapeutic Interchange – This is where you are unable to take a medication for reasons like an allergy, intolerance, etc., a medication might not work for you and your prescriber may write a prescription for a medication that is not on the approved drug list.

Specialty Medications – This is a review of a medication that is considered more complex for a specific disease and requires specific attention and handling during the prior authorization review process. For these medications, you may have to get them through a specialty pharmacy. Your prescriber will work with Gainwell Pharmacy Services to make sure you can obtain the medication you need as quickly as possible.

1.2.4 Excluded Services

Gainwell will not pay for the following categories that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for treatment of obesity.
- Drugs for treatment of infertility.
- Drugs for the treatment of erectile dysfunction.
- DESI drugs or drugs that may have been determined to be identical, similar, or related.
- Drugs that are eligible to be covered by Medicare Part D.
- Over-the-counter drugs that are not listed in accordance with paragraph C of OAC rule 5160-9-03.
- Drugs being used for indications not approved by the Food and Drug Administration (FDA) unless supported by compelling clinical evidence.

1.2.5 Additional Services

The Gainwell Pharmacy team can also assist you with the below services by calling our member help desk at 1-833-491-0344 (TTY 1-833-655-2437). You can also access this information on your member portal by logging in at https://spbm.medicaid.ohio.gov.

- Locating a pharmacy to fill the prescription you were given by your provider.
- Verifying you have active pharmacy coverage.
- Obtaining diabetic supplies covered through your pharmacy benefit.
- Obtaining durable medical equipment (DME) covered through your pharmacy benefit.

1.3 Requests for Appeals, Grievances, or State Hearings

Grievance

If you are unhappy with anything in relation to Gainwell Pharmacy Services or our providers, please contact us as soon as possible. This is called a grievance.

To contact us you can:

- Call member services at 1-833-491-0344 (TTY 1-833-655-2437) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below or online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter telling us you are unhappy. Please be sure to include your first and last name,

your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail: Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

Once you contact Gainwell to submit your grievance, we will follow up with you by telephone, mail delivery, or other appropriate means with the below timeframes:

- Two (2) working days for grievances about not being able to get medications you need.
- Thirty (30) calendar days for all other grievances.

Appeal

If you receive a notice from us that you disagree with, you may ask for an appeal within sixty (60) calendar days after the date of the notice. Gainwell will provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If you believe fifteen (15) calendar days could seriously jeopardize your life, physical or mental health or ability to attain, maintain, or regain maximum function, contact Gainwell Member Services at the number listed below as soon as possible to expedite your review process. To request an appeal, you can:

- Call Member Services at 1-833-491-0344 (TTY 1-833-655-2437) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below, or complete online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter. Please be sure to include your first and last name, Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail: Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

When submitting an appeal, please include the following information:

- Your name and Medicaid ID number on your card.
- Your prescriber's name.
- The reason you disagree with the outcome provided by Gainwell.
- Any documentation or information to support your request to have your decision overturned

Gainwell must provide you with an answer to your appeal within fifteen (15) calendar days from the date you contact us. If we do not change our decision, you will be notified in writing and will be provided your right to request a State hearing. You must complete the appeal process before you are able to request a State hearing.

If we need more time to make a decision for either a grievance or appeal, we will send you a letter telling you we need to take up to fourteen (14) more calendar days. That letter will also provide you with information as to why we need more time to complete your request.

State Hearing
You must complete the Gainwell appeal process before you are able to request a State hearing. A State hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from Gainwell, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). During this meeting, you will explain why you think Gainwell Pharmacy Services did not make the right decisions and Gainwell will explain the reasons for making our decision. A decision will be made by the hearing officer based on rules, regulations, and information provided during the hearing.

You will be notified of your right to request a State hearing if we do not change our decision as a result of appeal to Gainwell. If you would like to request a State hearing, you or an authorized representative must request a hearing within ninety (90) calendar days of your denied appeal from Gainwell.

To request a hearing, you can sign and return the State hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748 (TTY/TDD 614-728-2985), or submit your request via email to bsh@jfs.ohio.gov. If you want information on free legal services, you can call the Ohio State Legal Services Association at 1-800-589-5888 for the local number to your legal aid office.

State hearing decisions are usually issued no later than seventy (70) calendar days after the request is received. If it is determined that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three (3) business days after the request is received. Expedited decisions are for situations when the standard review time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

1.4 Change Recommendations

As a member of Gainwell Pharmacy Services, you have a membership right to make recommendations regarding rights and responsibilities surrounding medication coverage.

Recommendations can be emailed to Gainwell Pharmacy Services as OH_MCD_PBM@gainwelltechnologies.com or call Member Services at 1-833-491-0344 (TTY/TDD 1-614-728-2985).

1.5 Pharmacy Access

Gainwell Pharmacy Services offers a member portal for you to log in and manage your pharmacy needs. To log in to your personal member portal, visit https://spbm.medicaid.ohio.gov and log in with your personal information that you have set up for your account.

To sign up for a provider through the Gainwell Member Portal, you can follow the directions on the website at https://spbm.medicaid.ohio.gov or call your Member Services toll free at 1-833-491-0344 (TTY 1-833-655-2437) to speak with a Gainwell Pharmacy Services agent to receive step-by-step assistance to sign up for access.

1.6 Emergency Outpatient Drug

In the event of an emergency situation, you will have the option to receive a 72-hour (3 day) supply of your medically necessary medication. If you have difficulties with this process, please contact Gainwell Pharmacy Services at 1-833-491-0344 (TTY 1-833-655-2437).

1.7 Non-Discrimination Statement

Gainwell Pharmacy Services follows State and Federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, gender, gender identity, sexual orientation, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, military status, veteran status, ancestry, the need for health services to receive any covered services or geographic location.

Gainwell has no moral or religious objections to services that we provide for Ohio Department of Medicaid members.

If you are in need of any additional services below, please contact Member Services toll free at 1-833-491-0344 (TTY 1-833-655-2437) to speak to a team member at no additional charge:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in other languages, including, but not limited to, Spanish, Somali, and Arabic
- Written information in alternative formats including, but not limited to, braille and large print

1.8 Provider Network Statement

Gainwell works with pharmacies to fill prescriptions close to your home for easy access to any of your medication needs. Many of the pharmacies offer services including prescription home delivery, medication management and assistance if you have limited English, hearing or sight difficulties, or a disability needing extra support. Specialty pharmacies also are available to provide medications with specific handling, storage, and distribution requirements to treat high risk, complex, or rare disease (s). If there are any changes to these pharmacies, we will be sure to let you know via the website, Gainwell Member Portal, or mailings as determined by your preferred communication request.

Gainwell does not cover prescription fills at pharmacies that are not signed up (Out of Network) to dispense medications for Ohio Medicaid members, which includes, but is not limited to, pharmacies that are far away from your home, except for emergency situations (if out of the State in an emergency or if an Ohio pharmacy cannot supply the medication).

1.9 Pharmacy Provider Network

You can obtain information on how to locate a pharmacy covered in your network by accessing the Pharmacy Provider Directory online at https://spbm.medicaid.ohio.gov or through logging in to your Gainwell Member Portal at https://spbm.medicaid.ohio.gov. You can request a paper copy of the Pharmacy Provider Directory by calling Member Services toll free at 1-833-491-0344 (TTY 1-833-655-2437).

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