OH H5280-001

2024 Member Handbook

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan

Ohio H5280-001

Serving the following : Butler, Clark, Clermont, Clinton, Delaware, Franklin, Greene, Hamilton, Madison, Montgomery, Pickaway, Union, and Warren

Effective January 1 through December 31, 2024

MOLINA HEALTHCARE

MyCareOhio
Connecting Medicare + Medicaid

Molina Dual Options MyCare Ohio (Medicare-Medicaid Plan) Member Handbook

01/01/2024 – 12/31/2024

Your Health and Drug Coverage under Molina Dual Options MyCare Ohio (Medicare-Medicaid Plan)

Member Handbook Introduction

This handbook tells you about your coverage under Molina Dual Options MyCare Ohio through 12/31/2024. It explains health care services, behavioral health coverage, prescription drug coverage, and home and community-based waiver services (also called long-term services and supports). Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

This plan, Molina Dual Options MyCare Ohio, is offered by Molina Healthcare of Ohio. When this *Member Handbook* says "we," "us," or "our," it means Molina Healthcare of Ohio. When it says "the plan" or "our plan," it means Molina Dual Options MyCare Ohio.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. The call is free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 665-4623, servicio TTY al 711, de lunes a viernes, de 8:00 a. m. a 8:00 p. m., hora local. La llamada es gratuita.

You can get this document for free in other formats, such as large print, braille, or audio. Call (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. The call is free.

If you have any problems reading or understanding this handbook or any other Molina Dual Options MyCare Ohio information, please contact Member Services. We can explain the information or provide the information in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing impaired, special help can be provided.

You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request so you do not need to make separate requests each time we send you information.

To get this document in a language other than English or in an alternate format, call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. Member Services can help you make or change a standing request. You can also contact your Care Manager for help with standing requests. To permanently change your preferred language or format with your county caseworker, call the Ohio Medicaid Hotline at (800) 324-8680, TTY: 711, Monday – Friday, 7 a.m. to 8 p.m. and Saturday, 8 a.m. to 5 p.m., local time) to update your record.

2024 Molina Dual Options MyCare Ohio

Table of Contents

Disclaimers

- Molina Dual Options MyCare Ohio Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

- Coverage under Molina Dual Options MyCare Ohio is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

- Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Molina Dual Options MyCare Ohio, a health plan that covers all your Medicare and Medicaid services. It also tells you what to expect as a member and what other information you will get from Molina Dual Options MyCare Ohio. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

2024 Molina Dual Options MyCare Ohio

Table of Contents

A. Welcome to Molina Dual Options MyCare Ohio

Molina Dual Options MyCare Ohio, offered by Molina Healthcare of Ohio, is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Care Managers and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Molina Dual Options MyCare Ohio was approved by the Ohio Department of Medicaid (ODM) and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MyCare Ohio program.

The MyCare Ohio program is a demonstration program jointly run by ODM and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

A Health Plan Designed for You

We put you at the center of your care. We will build your personal care plan to fit your needs, not the other way around.

- We begin with a full health assessment. A Molina Dual Options MyCare Ohio registered nurse or social worker will help you with this assessment. The assessment helps us meet your needs for medical services, transportation, food, shelter and other community resources. We use this information to create a personal care plan just for you.
- Your care team works on your behalf to address your health issues quickly. Your care team can connect you with a doctor or other providers.
- Your Care Manager is committed to you. They will work with you to manage your health conditions and reduce the need for hospital visits.
- Your Care Manager will help make any moves between the hospital, nursing facility and your home as smooth as possible.
- A Community Connector who lives in your area can make home visits and talk to your care team. Community Connectors can help you solve problems before they become more serious. Because they live in your community, Community Connectors can connect you with local social services like food, housing and work.

Communication is very important in helping you be your healthiest and safest at home. We will talk to you often and treat you as a partner in your care.

B. Information about Medicare and Medicaid

You have both Medicare and Medicaid. Molina Dual Options MyCare Ohio will make sure these programs work together to get you the care you need.

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

B2. Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Ohio Medicaid must approve Molina Dual Options MyCare Ohio each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and Ohio Medicaid approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medicaid services will not be affected.

C. Advantages of this plan

You will now get all your covered Medicare and Medicaid services from Molina Dual Options MyCare Ohio, including prescription drugs. **You do not pay extra to join this health plan**.

Molina Dual Options MyCare Ohio will help make your Medicare and Medicaid benefits work better together and work better for you. **Some of the advantages include**:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a Care Manager. This is a person who works with you, with Molina Dual Options MyCare Ohio, and with your care providers to make sure you get the care you need. They will be a member of your care team.
- You will be able to direct your own care with help from your care team and Care Manager.
- The care team and Care Manager will work with you to come up with a care plan specifically designed to meet your needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - Your care team will make sure your test results are shared with all your doctors and other providers.

D. Molina Dual Options MyCare Ohio's service area

Molina Dual Options MyCare Ohio is available only to people who live in our service area. To keep being a member of our plan, you must keep living in this service area.

Our service area includes these counties in Ohio: Butler, Clark, Clermont, Clinton, Delaware, Franklin, Greene, Hamilton, Madison, Montgomery, Pickaway, Union, and Warren. If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state. Refer to Chapter 8 for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for membership in our plan as long as:

- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it); **and**
- you have Medicare Parts A, B and D; **and**
- you have full Medicaid coverage; **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are 18 years of age or older at time of enrollment.

Even if you meet the above criteria, you are not eligible to enroll in Molina Dual Options MyCare Ohio if you:

- have other third party creditable health care coverage; **or**
- have intellectual or other developmental disabilities and get services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID); **or**
- are enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

Additionally, you have the choice to disenroll from Molina Dual Options MyCare Ohio if you are a member of a federally recognized Indian tribe.

If you believe that you meet any of the above criteria and should not be enrolled, please contact Member Services for assistance.

F. What to expect when you first join a health plan

When you first join the plan, you will get a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. We will complete a health assessment with you. We use the health assessment to create a personal care plan just for you. The assessment will ask about your current medical and mental health needs. The assessment also helps us meet your needs for transportation, food, shelter and other community resources.

We will reach out to you to complete the health assessment. One of our nurses or social workers will work with you to complete the health assessment. You will complete it through an in-person visit, telephone call or by mail. If you get a health assessment in the mail, please complete it as soon as possible. Then return it in the envelope provided.

If you are on the MyCare Ohio Waiver, you will always complete your health assessment in person.

If Molina Dual Options MyCare Ohio is new for you, you can keep using the doctors you use now for at least 90 days after you enroll. Also, if you already had previous approval to get services, our plan will honor the approval until you get the services. This is called a "transition period." The New Member Letter included with your *Member Handbook* has more information on the transition periods. If you are on the MyCare Ohio Waiver, your Member Handbook Supplement or "Waiver Handbook" also has more information on transition periods for waiver services.

After the transition period, you will need to use doctors and other providers in the Molina Dual Options MyCare Ohio network for most services. A network provider is a provider who works with the health plan. Refer to Chapter 3 for more information on getting care. Member Services can help you find a network provider.

If you are currently using a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services right away so we can arrange the services and avoid any billing issues.

G. Your care plan

Your care plan is the plan for what health services you will get and how you will get them.

After your health care needs assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make your care plan.

Your care team will continuously work with you to update your care plan to address the health services you need and want.

H. Molina Dual Options MyCare Ohio monthly plan premium

Molina Dual Options MyCare Ohio does not have a monthly plan premium.

I. The Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9 page 144. You can also call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or Medicare at 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. You can also refer to the Member Handbook at www.MolinaHealthcare.com/Duals or download it from this website.

The contract is in effect for months in which you are enrolled in Molina Dual Options MyCare Ohio between 01/01/2024 and 12/31/2024.

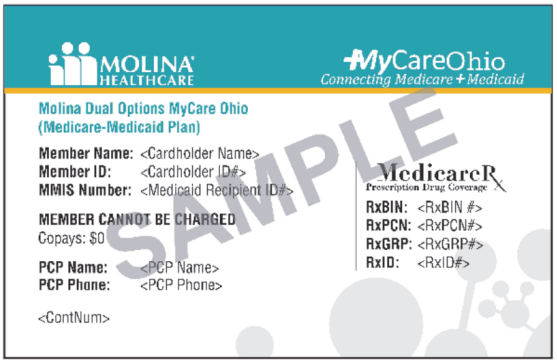
J. Other important information you will get from us

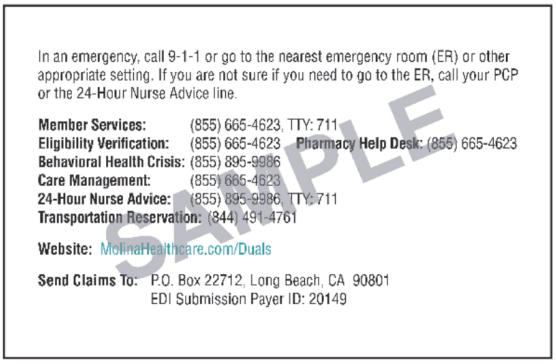
You will also get a Molina Dual Options MyCare Ohio Member ID Card, a New Member Letter with important information, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a List of Covered Drugs. Members enrolled in a

home and community-based waiver will also get a supplement to their *Member Handbook* that gives information specific to waiver services. If you do not get these items, please call Member Services for assistance.

J1. Your Molina Dual Options MyCare Ohio Member ID Card

Under the MyCare Ohio program, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions covered by the plan. Here's a sample card to show you what yours will look like:





If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, this is the only card you need to get services. You will no longer get a monthly Medicaid card. You also do not need to use your red, white, and blue Medicare card. Keep your Medicare card in a safe place, in case you need it later. If you show your Medicare card instead of your Molina Dual Options MyCare Ohio Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 to find out what to do if you get a bill from a provider.

J2. New Member Letter

Please make sure to read the New Member Letter sent with your *Member Handbook* as it is a quick reference for some important information. For example, it has information on things such as when you may be able to get services from providers not in our network, previously approved services, transportation services, and who is eligible for MyCare Ohio enrollment.

J3. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Molina Dual Options MyCare Ohio network. While you are a member of our plan, you must use network providers and pharmacies to get covered services. There are some exceptions, including when you first join our plan (refer to page 10) and for certain services (refer to Chapter 3).

You can ask for a printed *Provider and Pharmacy Directory* at any time by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. You can also refer to the Provider and Pharmacy Directory at www.MolinaHealthcare.com/Duals, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

Definition of network providers

- Molina Dual Options MyCare Ohio's network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

For a full list of network providers, refer to the *Provider and Pharmacy Directory*.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

Network providers should not bill you directly for services covered by the plan. For information about bills from network providers, refer to Chapter 7 page 118.

Definition of network pharmacies

- Network pharmacies are the pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except in an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy.

J4. List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Molina Dual Options MyCare Ohio.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5 for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, you can visit the plan's website at www.MolinaHealthcare.com/Duals or call Member Services (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

J5. List of Durable Medical Equipment (DME)

With this *Member Handbook,* we sent you Molina Dual Options MyCare Ohio's List of Durable Medical Equipment. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at www.MolinaHealthcare.com/Duals. Refer to Chapter 4 to learn more about DME.

If you are new to Molina Dual Options MyCare Ohio and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. If you disagree with your doctor, you can ask them to refer you for a second opinion.

J6. Member Handbook Supplement or "Waiver Handbook"

This supplement provides additional information for members enrolled in a home and community-based waiver. For example, it includes information on member rights and responsibilities, service plan development, care management, waiver service coordination, and reporting incidents.

J7. The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (or EOB).

The *EOB* tells you the total amount we, or others on your behalf, have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

An *EOB* is also available when you ask for one. To get a copy, contact Member Services.

K. How to keep your membership record up to date

You can keep your membership record up to date by letting us know when your information changes.

You should also tell your local County Department of Job and Family Services (CDJFS) office when your information changes. Tell your local CDJFS office about changes to your phone number, mailing address, or email address. You can find the phone number for your local CDJFS here: http://www.jfs.ohio.gov/county/county_directory.pdf. You can also call the Ohio Medicaid Hotline at (800) 324-8680 for help at no cost. Call the Ohio Medicaid Hotline from Monday to Friday, 7 a.m. to 8 p.m. or Saturdays 8 a.m. to 5 p.m., local time.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs are covered and any**

drug copay amounts for you. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- changes to your name, your address, or your phone number
- changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- admission to a nursing home or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- changes in who your caregiver (or anyone responsible for you) is
- you are part or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).
- If you have to use a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

Online and Mobile Member Self-Service

You can update your information online with My Molina, a password protected website. My Molina is available online 24 hours a day, 7 days a week. To sign up, visit MyMolina.com.

Use My Molina to:

- Update your address or phone number
- Find or change providers
- View, print or request your ID card
- File a complaint
- View your claims history
- View your medical profile (assessments, conditions, care plan)
- Share your records with your care team
- Get health reminders for services you need
- Message your Care Manager

My Molina mobile app for Smartphones

You can view information about your plan anytime, anywhere with the My Molina Mobile app. Download the app on the iPhone App Store or Google Play at no cost.

Sign into the app using your My Molina user ID and password or tap "New user?" to register.

Use the My Molina mobile app to:

- View, fax or email your ID card
- Call the 24-hour Nurse Advice Line, Member Services, Transportation, Care Management and other support services
- Find, change, or favorite your providers
- Find a pharmacy or urgent care location
- Learn about your symptoms if you are sick (Android users only)
- See your personal health records and service history
- View your Summary of Benefits

K1. Privacy of your personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Molina Dual Options MyCare Ohio, the State of Ohio, Medicare, and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. How to contact Molina Dual Options MyCare Ohio Member Services

CALL	(855) 665-4623 This call is free. Monday – Friday, 8 a.m. to 8 p.m., local time There are other options after our normal hours. These include self-service and voicemail. Use these options on weekends and holidays. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday – Friday, 8 a.m. to 8 p.m., local time
FAX	**For Member Services:** Fax: (888) 295-4761 **For Part D (Rx) Services:** Fax: (866) 290-1309 **For Complaints & Appeals:** Fax: (562) 499-0610
WRITE	**For Member Services:** P.O. Box 349020 Columbus, OH 43234-9020 **For Part D (Rx) Services:** 7050 Union Park Center Suite 200 Midvale, UT 84047 If you are sending us an appeal or complaint, you can use the form in Chapter 9. You can also write a letter telling us about your question, problem, complaint, or appeal. **For Complaints & Appeals:** Attention: Grievance and Appeals P.O. Box 22816 Long Beach, CA 90801-9977
WEBSITE	www.MolinaHealthcare.com/Duals

A1. When to contact Member Services

- Questions about the plan
- Questions about claims or billing from providers
- Member Identification (ID) Cards
    - Let us know if you didn't get your Member ID Card or you lost your Member ID Card.
- Finding network providers
    - This includes questions about finding or changing your primary care provider (PCP).
- Getting long-term services and supports
    - In some cases, you can get help with daily health care and basic living needs. If it is determined necessary by Ohio Medicaid and Molina Dual Options MyCare Ohio, you may be able to get assisted living, homemaker, personal care, meals, adaptive equipment, emergency response, and other services.
- Understanding the information in your *Member Handbook*
- Recommendations for things you think we should change
- Other information about Molina Dual Options MyCare Ohio
    - You can ask for more information about our plan, including information regarding the structure and operation of Molina Dual Options MyCare Ohio and any physician incentive plans we operate.
- Coverage decisions about your health care and drugs
    - A coverage decision is a decision about:
        - your benefits and covered services and drugs, **or**
        - the amount we will pay for your health services and drugs.
    - Call us if you have questions about a coverage decision.
    - To learn more about coverage decisions, refer to Chapter 9.
- Appeals about your health care and drugs
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
    - To learn more about making an appeal, refer to Chapter 9.
- Complaints about your health care and drugs
    - You can make a complaint about us or any provider or pharmacy. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to Section E below).

  - If your complaint is about a coverage decision about your health care or drugs, you can make an appeal (refer to the section above).
  - You can send a complaint about Molina Dual Options MyCare Ohio right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can send a complaint about Molina Dual Options MyCare Ohio directly to Ohio Medicaid. Call 1 800-324-8680. This call is free. Refer to page 26 for other ways to contact Ohio Medicaid.
  - You can send a complaint about Molina Dual Options MyCare Ohio to the MyCare Ohio Ombudsman. Call 1-800-282-1206. This call is free.
  - To learn more about making a complaint, refer to Chapter 9.
- Payment for health care or drugs you already paid for
  - For more on how to ask us to assist you with a service you paid for or to pay a bill you got, refer to Chapter 7.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9 for more on appeals.

B. How to contact your Care Manager

Your Care Manager is your main contact with your health plan. This person helps you manage all of your providers and services. They will make sure you get what you need. Your Care Manager will tell you their name and phone number.

You and/or your caregiver may change the Care Manager assigned to you. You can do this by calling Member Services or your current Care Manager. We may change your Care Manager based on your medical and cultural needs or location.

If you have questions, call your Care Manager or Member Services.

CALL	(855) 665-4623 This call is free. The Care Manager call line is available 24 hours a day, 7 days a week, 365 days a year. There are other options after our normal hours. These include self-service and voicemail. Use these options on weekends and holidays. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week, 365 days a year.
WRITE	Molina Dual Options MyCare Ohio P.O. Box 349020 Columbus, OH 43234-9020
WEBSITE	www.MolinaHealthcare.com/Duals

C. How to contact the 24-Hour Nurse Advice Call Line

You can call Molina Healthcare's Nurse Advice Line 24 hours a day, 365 days a year. The service connects you to a qualified nurse who can give you health care advice in your language and help you get the care you need.

Our Nurse Advice Line is available to provide services to all Molina Healthcare members across the United States. The Nurse Advice Line is a URAC-accredited health call center. The URAC accreditation means that our nurse line has demonstrated a comprehensive commitment to quality care, improved processes and better patient outcomes. Our Nurse Advice Line is also certified by NCQA in Health Information Products (HIP) for our 24/7/365 Health Information Line. NCQA is designed to comply with NCQA health information standards for applicable standards for health plans.

CALL	(855) 895-9986 This call is free. The 24-Hour Nurse Advice and Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week, 365 days a year

C1. When to contact the Nurse Advice Call Line

- Questions about your health care

D. How to contact the 24-Hour Behavioral Health Crisis Line

You can call the Behavioral Health Crisis Line if you need help right away or are not sure what to do for:

- Sadness that does not get better
- Thoughts of harming yourself or others
- Feeling hopeless or helpless
- Feeling worthless
- Guilt
- Difficulty sleeping
- Poor appetite or weight loss
- Loss of interest
- Substance use disorders

You can also call the 988 Suicide & Crisis Lifeline for free and confidential support. Call 988 any time if you are having thoughts of suicide or are experiencing emotional distress.

If you have an emergency that may cause harm or death to you or others, go to the nearest hospital emergency room. You can also call 911.

CALL	(855) 895-9986 This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week, 365 days a year.

D1. When to contact the Behavioral Health Crisis Line

- Questions about behavioral health services
- Questions about substance use disorder services

E. How to contact the Quality Improvement Organization (QIO)

An organization called Livanta serves as Ohio's QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our plan.

CALL	1-888-524-9900
TTY	1-888-985-8775 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

E1. When to contact Livanta

- Questions about your health care
  - You can make a complaint about the care you got if you:
    - have a problem with the quality of care,
    - think your hospital stay is ending too soon, **or**
    - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

F. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

G. How to contact the Ohio Department of Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, co-insurance and copays except for prescriptions. Medicaid covers long-term care services such as home and community-based "waiver" services and assisted living services and long-term nursing home care. It also covers dental and vision services.

You are enrolled in Medicare and in Medicaid. Molina Dual Options MyCare Ohio provides your Medicaid covered services through a provider agreement with Ohio Medicaid. If you have questions about the help you get from Medicaid, call the Ohio Medicaid Hotline.

CALL	1-800-324-8680 This call is free. The Ohio Medicaid Hotline is available Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm.
TTY	1-800-292-3572 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The Ohio Medicaid TTY number is available Monday through Friday from 7:00 am to 8:00 pm, and Saturday from 8:00 am to 5:00 pm.
WRITE	Ohio Department of Medicaid Bureau of Managed Care 50 W. Town Street, Suite 400 Columbus, Ohio 43215
EMAIL	bmhc@medicaid.ohio.gov
WEBSITE	www.medicaid.ohio.gov/provider/ManagedCare

You may also contact your local County Department of Job and Family Services if you have questions or need to submit changes to your address, income, or other insurance. Contact information is available online at: jfs.ohio.gov/County/County_Directory.pdf.

H. How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MyCare Ohio Ombudsman also helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan.

The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers getting long-term services and supports. The MyCare Ohio Ombudsman is not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-800-282-1206 This call is free. The MyCare Ohio Ombudsman is available Monday through Friday from 8:00 am to 5:00 pm.
TTY	Ohio Relay Service: 1-800-750-0750 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Ohio Department of Aging Attn: MyCare Ohio Ombudsman 246 N. High Street, 1st Floor Columbus, Ohio 43215-2406
WEBSITE	www.aging.ohio.gov/wps/portal/gov/aging/care-and-living/get-help/get-an-advocate/my-care-ohio-ombudsman You can submit an online complaint at: aging.ohio.gov/Contact.

I. Other resources

Molina Help Finder

Molina Help Finder is an online tool to help you find low- and no-cost community resources. Find resources when and where you need them to meet basic needs like:

- Food
- Housing
- Transportation
- Health
- Job training
- Childcare
- Education
- Work
- Legal

CALL	Call Member Services at (855) 665-4623 (TTY 711) from 8 a.m. to 8 p.m., Monday to Friday for help finding community resources. You can also contact your Care Manager. It is important to let your Care Manager know about the services you need. Your Care Manager will help connect you to these resources.
TTY	711 This call is free.
WEBSITE	MolinaHelpFinder.com

Help to Renew your Medicaid Coverage Each Year

You must renew your eligibility for Medicaid with your local County Department of Job and Family Services (CDJFS) every 12 months to find out if you still qualify for Medicaid benefits. You will receive a renewal letter before your renewal date to remind you. The renewal letter will include the paperwork you need to complete to renew your eligibility. You may also renew your eligibility in person or online. The chart below tells you different ways to renew your eligibility.

You will lose your Medicaid eligibility if you do not complete the renewal paperwork. If you lose your Medicaid eligibility, you will no longer be covered by Molina Dual Options MyCare Ohio.

If you have already renewed your Medicaid eligibility in the past 12 months, you will not need to renew again until the next renewal period.

CALL	Call your local CDJFS office or county caseworker if you need help with the Medicaid renewal process. They collect and process the forms. You can find the number for your local CDJFS here: http://www.jfs.ohio.gov/county/county_directory.pdf. You can also call the Ohio Medicaid Hotline for help at no cost. Call (800) 324-8680.
MAIL	Complete the renewal form you received in the mail. Send it to your local CDJFS office. You can find the address on the front page of the letter. You can also find the address here: http://www.jfs.ohio.gov/county/county_directory.pdf.
IN PERSON	You can go to your local CDJFS office to fill out the forms. Bring the documents you need to report your income. You can fill out a form in person. You do not need to schedule an appointment. You can find the address for your local CDJFS office here: http://www.jfs.ohio.gov/county/county_directory.pdf.
WEBSITE	Visit the Ohio Medicaid Hotline Member Portal to renew your benefits online. Go to https://members.ohiomh.com/ to register or log in to your account.
OTHER	Other resources can help you renew your benefits at no cost. • Find local help at https://localhelp.healthcare.gov. • Call 2-1-1, a private resource you can use 24/7.

Chapter 3: Using the plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Molina Dual Options MyCare Ohio. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable medical equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information about "services," "covered services," "providers," "network providers," and "network pharmacies"

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment, and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4.

Providers are doctors, nurses, and other people who deliver services and care. The term providers also include hospitals, home health agencies, clinics, and other places that deliver health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you pay nothing for covered services. The only exception is if you have a patient liability for nursing facility or waiver services. Refer to Chapter 4 for more information.

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you get. When you use a network pharmacy, you pay nothing for your prescription drugs. Refer to Chapter 6 for more information.

B. Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

Molina Dual Options MyCare Ohio covers health care services covered by Medicare and Medicaid. This includes behavioral health and long-term services and supports.

Molina Dual Options MyCare Ohio will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit**. Refer to Chapter 4 for information regarding covered benefits, including the plan's Benefits Chart.
- The care must be **medically necessary**. Medically necessary means you need services, supplies, or drugs to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice.
- The care you get must be prior authorized by Molina Dual Options MyCare Ohio when required. For some services, your provider must submit information to Molina Dual Options MyCare Ohio and ask for approval for you to get the service. This is called prior authorization (PA). Refer to the chart in Chapter 4 for more information.

- You must choose a network provider to be your **primary care provider (PCP)** to manage your medical care. Although you do not need approval (called a referral) from your PCP to use other providers, it is still important to contact your PCP before you use a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.
    - To learn more about choosing a PCP, refer to page 38.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). Here are some cases when this rule does not apply:
    - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to Section I, page 46.
    - If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. Molina Dual Options MyCare Ohio requires prior approval to get non-emergency care from an out-of-network provider. In this situation, we will cover the care at no cost to you. To learn about getting approval to use an out-of-network provider, refer to Section D, page 36.
    - The plan covers services you got at out-of-network Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the Provider and Pharmacy Directory.
    - If you are getting assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to get the services from that out-of-network provider.
    - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
    - If you are new to our plan, you may be able to continue to use your current out-of-network providers for a period of time after you enroll. This is called a "transition period." For more information, refer to Chapter 1 *of this handbook and your* New Member Letter.

C. Information about your care team and Care Manager

C1. What care management is

Molina Dual Options MyCare Ohio provides all members with care management services. Care management services help coordinate your care and health services, so you get the care you need to meet your health goals. The professionals who provide these services are called Care Managers. All Care Managers are licensed nurses or social workers. They are part of a care team made up of other health care professionals and support staff.

Your Health Assessment

When you first join our plan, we will reach out to you to complete a health assessment within the first 75 days. Your assessment day depends on your health needs. We will schedule your assessment at the best time available for you. We use the health assessment to create a personal care plan just for you. The assessment will ask about your current medical and mental health needs. The assessment also helps us meet your needs for transportation, food, shelter and other community resources.

One of our nurses or social workers will work with you to complete the health assessment. You will complete it through an in-person visit, telephone call or by mail. If you get a health assessment in the mail, please complete it as soon as possible. Then return it in the envelope provided.

If you are on the MyCare Ohio Waiver, you will always complete your health assessment in person.

What is included in my care management services?

Your care management services include:

- A health assessment to be sure we understand your health needs. This is especially important if you have a chronic disability or condition that requires special help.
- Regular ongoing assessments based on your needs and preferences. An assessment will also happen if there are any changes in your health care or life that could impact your care.
- A personal care plan developed according to your own goals, preferences and needs.
    - A care plan is a plan you and your care team create with your Care Manager. Your care plan lists your personal goals and ideas for how to reach those goals. Plus, it helps keep track of your progress toward those goals. When your care plan is updated, you will get a copy. You can choose to get a copy by mail or by email. You can also ask for a copy at any time from your Care Manager.
    - You can view your care plan at any time on MyMolina.com or on the My Molina mobile phone app.

Who is part of my care team?

Your care team may include:

- You
- Your family members and/or caregiver(s)
- Your Primary Care Provider (PCP)
- Your Care Manager
- Other doctors who provide care to you

C2. How you can contact your Care Manager

You can call Member Services to talk to your Care Manager or schedule a visit. Call Member Services at (855) 665-4623, Monday - Friday, 8 a.m. to 8 p.m., local time. Call TTY: 711 for the hearing impaired. The call is free. Your Care Manager or other members of your Care Management Team are ready to help.

You can send a message to your Care Manager through MyMolina.com or the My Molina mobile phone app. They will call you within 48 hours.

You can also reach a Care Management Team member 24 hours a day, 7 days a week by calling the 24-Hour Nurse Advice Line at (855) 895-9986, TTY: 711.

C3. How you will interact with your Care Manager and care team

Your Care Manager is committed to helping you. Your Care Manager helps you manage your health conditions and reduce the need for hospital visits. Your Care Manager also:

- Helps you manage your providers and services
- Is your point of contact for your care management needs
- Works with your care team to make sure you get the care you need

Your Care Manager will schedule care team conferences. This means that you can meet regularly with members of your care team. Together, your Care Manager and care team will:

- Ask questions to learn more about your condition and your needs
- Work with you to create a care plan that includes your health goals
- Make sure your preferences and needs are part of your care plan
- Talk with you about steps you want to take, or could take, to reach the goals in your care plan
- Help you figure out what services you need to get, how to get those services (including local resources) and which providers can give you care
- Help you find and schedule appointments with qualified providers
- Remind you of important health appointments
- Help you understand how to care for yourself
- Make sure medical tests and lab tests are done, and that the results are shared with your providers as needed
- Work with your providers to make sure they know all the medicines you take to reduce side effects

If you are in the hospital or a nursing facility, members of your care team may visit you or contact you. Your care team will make sure you are getting the attention, care and services you need. Once you go home, we may also visit you or contact you so we can help you with your transition. We will help you get the care you need at home.

Please remember, your providers need to have your permission before sharing your medical information with other providers.

C4. How you can change your Care Manager

We will assign your Care Manager to you. You or someone authorized to act on your behalf may change the Care Manager assigned to you. You can do this by calling Member Services or your current Care Manager. We may change your Care Manager based on your medical and cultural needs or location.

Tell us what you think!

Molina Dual Options MyCare Ohio makes every effort to give you and your family the best care. If you get a survey in the mail that asks for your feedback on your health plan and providers, please take the survey. Your answers will help us learn how to serve you better. You can also call Member Services at any time if you have suggestions for us.

D. Care from primary care providers, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of "PCP" and what a PCP does

A Primary Care Provider (PCP) is a doctor, certified nurse practitioner (CNP), physician assistant or other health care professional who gives you regular health care. Your PCP may be a general practitioner (doctor) or specialize in:

- Family practice (care for people of any age)
- Internal medicine (care for adults with an illness or disease)
- Obstetrics and gynecology (OB/GYN, or reproductive care for women)
- Geriatrics (care for older adults)
- Pediatrics (care for children)

Your PCP may also be a medical home or clinic, like a Federally Qualified Health Center (FQHC).

You may need to have a specialist provider as your PCP. You may need this if you have complex medical needs. We have a network of specialist providers to care for our members. If you need a specialist as your PCP, Member Services can help you find one.

Your PCP will provide most of your care. Your PCP will help you set up or coordinate the rest of the covered services you get as a member of our plan. Coordinating your services means checking with or asking other providers about your care and how it is going. This includes:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care

In some cases, your PCP will need to get prior approval from us. Your PCP may need your past medical records to provide or coordinate your medical care. Talk to your current PCP about sending your past medical records to their office.

What should you do if you need after-hours or 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:

- Sore throat or cough
- Flu
- Migraine or headache
- Earaches or ear infections
- Fever without rash
- Vomiting
- Painful urination
- Persistent diarrhea
- Minor accidents or falls
- Minor injury like a common sprain or shallow cut

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 your appointment right away, there are some steps you can take to stop your injury or illness from getting worse.

1. Call your PCP for advice. If you cannot get an appointment, ask your PCP what to do next. Even if your provider's office is closed, someone may answer. You may also be able to leave a message.
2. If you cannot reach your provider's office, you can **call our 24-Hour Nurse Advice and Behavioral Health Crisis Line**. Registered nurses are always ready to answer your questions. Call (855) 896-9986 (TTY: 711) any time, day or night, to speak with a nurse.
3. Go to a network walk-in clinic or a network urgent care center listed in the provider directory. If you visit an urgent care center, always call your PCP after your visit to schedule follow-up care.

Your choice of PCP

Your relationship with your PCP is important. When you pick your PCP, try to choose one close to your home. This will make it easier to get to your visits and get the care you need when you need it.

You can use our Provider/Pharmacy Directory to find a PCP in the Molina Dual Options MyCare Ohio network. The directory is on our website at www.MolinaProviderDirectory.com/OH. If you need a printed copy of the directory or help picking a PCP, call Member Services. You can also call your Care Manager for help.

Once you pick your PCP, call the PCP to set up your first visit. Talk to your PCP about sending your past medical records to their office. This way, your PCP will have your medical history and will know about any existing health care conditions you may have. Your PCP is now responsible for all your regular health care services. They should be the first one you call with any health concerns.

The name and office phone number of your PCP is printed on your member ID card. If the name of the PCP you are seeing is not the name listed on your member ID card, call Member Services. We'll send you a new member ID card with the name of the PCP you are seeing.

Option to change your PCP

You may change your PCP for any reason. *You can change your PCP to another network PCP monthly*. Also, it's possible that your PCP might leave our plan's network. If your provider leaves our network, we can help you find a new PCP.

You can change your PCP once a month. If you ask to change your PCP during your first 30 days with the plan, the change will happen right away. If you ask any time after your first 30 days, the change will happen on the first day of the next month. We recommend you first visit your PCP to get to know them before changing. You can call Member Services if you want to learn more about any of our providers.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

We have many specialist providers to care for our members. If there is a specialist you want to use, ask your PCP. You do not need a referral to see a network provider, but your PCP can recommend other network providers for you.

For some services, you may need prior approval from us. Your PCP can ask for prior approval by fax or on our website. Please see the Benefits Chart in Chapter 4 for information about which services need prior approval.

D3. What to do when a provider leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make a complaint. Refer to Chapter 9 for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care, call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

If your provider leaves our plan, you will have to switch to another network provider. You will have a limited time to keep seeing your current provider while you look for a new one. This is called the transition of care period. If we find out your PCP is leaving the plan, we will let you know right away. We will help you switch to a new PCP so you can keep getting your covered services.

D4. How to get care from out-of-network providers

What if you need medical care that is covered by our plan, but there is not a network provider who can give you the care you need? You can get this care from an out-of-network provider. You will need prior approval from us to get services from an out-of-network provider. Your provider can ask for this prior approval. If you have questions or need help, call Member Services. If you get regular care from out-of-network providers without prior approval, you may have to pay the cost. The cost will not be paid by Medicare, Medicaid or our plan.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid.
- If you use a provider who is not eligible to participate in Medicare, you may have to pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. How to get long-term services and supports (LTSS)

You can call Member Services or your Care Manager to ask about enrolling in a waiver service that can offer you Long-Term Services and Supports. MyCare Ohio Waiver services are for members age 18 and older who the state of Ohio says meet a certain level of need. These services help individuals live and function independently. If you are enrolled in a waiver, please see your MyCare Ohio Home & Community-Based Services Waiver Member Handbook to learn more. It's also posted on our website.

If you become eligible for Long-Term Services and Supports, we will provide you a MyCare Ohio Home & Community-Based Services Waiver Member Handbook. You can call Member Services to ask for a copy. It's also posted on our website.

F. How to get behavioral health services

You can call Member Services or your Care Manager to ask about behavioral health services. Your Care Manager can help you to understand:

- What services you need
- How to get services (including local resources)
- Which providers can give you care

To learn more about behavioral health services that are covered as part of your plan, see Chapter 4.

G. How to get transportation services

G1. How to get transportation services

Your transportation benefits

As a member, you get an extra transportation benefit. You get an extra benefit of 30 one-way trips every calendar year. This benefit will get you to and from places where you get covered health care services. This includes your PCP and other providers, your dentist, the hospital, the pharmacy and more.

You may also use your extra benefit of 30 one-way trips for:

- Appointments to renew your Medicaid benefits with your local County Department of Job and Family Services (CDJFS)
- Supplemental Security Income (SSI) appointments
- Community Mental Health Services appointments
- Women, Infants and Children (WIC) appointments
- Food resources, such as the grocery store or food bank
- Pharmacy visits for medications or other needs

In addition to your 30 one-way trips, Molina Dual Options MyCare Ohio covers unlimited rides to members who get these services:

- Dialysis
- Chemotherapy
- Radiation
- Wheelchair transports

Transportation is always available to you if you must travel more than 30 miles to get services. These rides are unlimited, but only if there is not a provider closer to your home.

Transportation is always available to you if you are discharged from the hospital. Hospital discharges include emergency room, inpatient and outpatient discharges.

How to schedule a ride by phone

To schedule transportation services by phone, call (844) 491-4761 (TTY: 711) at least 48 hours before your appointment. Door-to-door service is available upon request. You may be picked up in a car, van, or medical transport vehicle.

How to cancel a scheduled trip by phone

If you need to cancel transportation you have scheduled, please call (844) 491-4761 (TTY: 711) to let us know 24 hours before your appointment. If you do not call to cancel 24 hours before your appointment, the ride may count as one of your 30 trips for the year.

Manage your rides with the Access2Care mobile app

You can schedule and manage your trips with the Access2Care phone app.

With the app, you can:

- Schedule or cancel rides
- View your current and upcoming rides
- Save addresses, like your home address or doctor's office

Visit the iPhone App Store or Google Play and search "A2C" to download.

Other types of rides we offer

Bus passes are available if you can get to and from the bus stop near your home and near your provider's office.

In some cases, you can get reimbursed (paid back) for the gas used to drive to a medical visit. Call your Care Manager or Member Services to see if you are eligible.

More information about transportation benefits

- To learn more about your transportation benefit, see the Benefits Chart in Chapter 4. The chart shows what kinds of rides are covered. Or you can call Member Services.

In addition to the transportation assistance that Molina Dual Options MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.

H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

H1. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or, if pregnant, to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:

- there is not enough time to safely transfer you to another hospital before delivery.
- a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital, or other appropriate setting. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP or Molina Dual Options MyCare Ohio. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- Be sure to tell the provider that you are a Molina Dual Options MyCare Ohio member. Show the provider your Molina Dual Options MyCare Ohio Member ID Card.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Also, if the hospital has you stay, please make sure Molina Dual Options MyCare Ohio is called within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. You can find the number to Member Services on the back of your ID card.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call (855)322-4079. Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

After the emergency is over, you may need follow-up care to get better. This is called post-stabilization care. This care is covered by our plan. If an out-of-network provider thinks you need follow-up care, they must call Provider Services at (855) 322-4079 to request prior authorization.

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.

What to do if you have a behavioral health emergency

A behavioral health emergency is a mental health or substance use condition that may cause extreme harm to the body or may cause death. Some examples of these emergencies are attempted suicide, danger to self or others, withdrawal from substances such as alcohol or drugs, so much functional harm that the person is not able to carry out actions of daily life, or functional harm that will likely cause death or serious harm to the body.

If you have a behavioral health emergency:

Go to the closest emergency room or call 911 right away.

- Tell the provider that you are a Molina Dual Options MyCare Ohio member. Show the provider your Molina Dual Options MyCare Ohio Member ID Card.
- If the hospital has you stay, it is important to make sure Molina Dual Options MyCare Ohio is called within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us.
- 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 after your emergency is over. The phone number is on the back of your ID card.
- After your emergency is over, call your doctor and follow up within 48 hours.

If you need help but it is not an emergency as described above, you can call the 988 Suicide & Crisis Lifeline for free and confidential support. Call 988 any time if you are having thoughts of suicide or are experiencing emotional distress.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn't really an emergency. As long as you reasonably thought your health or the health of your unborn child was in serious danger, we will cover your care.

However, after the doctor says it was not an emergency, we will cover your additional care only if:

- you use a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

H2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

You can get urgent care from any urgent care center in our network or CVS/Pharmacy® MinuteClinic®. Prior authorization is needed for urgent care centers not in network. You may also call the Nurse Advice Line at (855) 895-9986, TTY: 711, 24 hours a day, 7 days a week.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States or its territories.

H3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Molina Dual Options MyCare Ohio.

Please visit our website for information on how to obtain needed care during a declared disaster: www.MolinaHealthcare.com/Duals.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

I. What to do if you are billed directly for services covered by our plan

Providers should bill us for providing you covered services. You should not get a provider bill for services covered by the plan. If a provider sends you a bill for a covered service instead of sending it to the plan, you can ask us to pay the bill. Call Member Services as soon as possible to give us the information on the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you got a bill for covered services, **refer to Chapter 7 to learn what to do**.

I1. What to do if services are not covered by our plan

Molina Dual Options MyCare Ohio covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you may have to pay the full cost yourself**.

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you do not have PA from Molina Dual Options MyCare Ohio to go over the limit, you may have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are, how close you are to reaching them, and what your provider must do to ask to exceed the limit if they think it is medically necessary.

J. Coverage of health care services covered when you are in a clinical research study

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare or our plan approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers.

We encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your Care Manager should contact Member Services to let us know you will be in a clinical trial.

J2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

We will pay any costs if you volunteer for a clinical research study that Medicare does not approve but that our plan approves. If you are part of a study that Medicare *or our plan* has not approved, you will have to pay any costs for being in the study.

J3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

K. How your health care services are covered when you get care in a religious non-medical health care institution

K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

K2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is any care that is not voluntary and is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Our plan covers an unlimited number of days for an inpatient hospital stay (See the Benefits Chart in Chapter 4 to learn more).

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Molina Dual Options MyCare Ohio, you sometimes will not own DME, no matter how long you rent it.

Sometimes you will own the rented item after Molina Dual Options MyCare Ohio pays the rental fee for a certain number of months. Sometimes you will not own the item no matter how long it is rented.

In certain limited situations, we will transfer ownership of the DME item to you. Call Member Services to find out if you will own the DME item or if you will rent it. Member Services can help you understand the requirements you must meet to own the DME item. Your provider will tell you when we transfer ownership of a DME item to you.

L2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 11. You can also find more information about them in the Medicare & You 2024 handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or Medicare Advantage plan.

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Molina Dual Options MyCare Ohio covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.

Table of Contents

A. Your covered services

This chapter tells you what services Molina Dual Options MyCare Ohio covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, and information about what you pay for drugs is in Chapter 6.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan's rules. Refer to Chapter 3 for details about the plan's rules. However, you may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or your Care Manager at (855) 665-4623, TTY: 711, 24 hours a day, 7 days a week.

A1. During public health emergencies

During a public health emergency, Molina Dual Options MyCare Ohio will follow all public health orders as directed by state or federal mandates.

COVID-19 Treatment

Molina Dual Options MyCare Ohio will cover all COVID-19 testing, treatment, and vaccinations without copays.

COVID-19 Testing

You can find COVID-19 testing locations online at coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers.

There is no cost for you to get tested for COVID-19. Testing for COVID-19 helps identify, contain and decrease the spread of illness. Testing is available for people with or without symptoms.

COVID-19 Vaccinations

There is no cost for you to get a COVID-19 vaccine. The vaccines are safe and effective, and can help prevent serious illness, hospitalization, and death from COVID-19.

The Ohio Department of Health (ODH) has a search tool you can use to find a vaccine provider. You can search the directory by county and ZIP code. It displays providers currently getting shipments of COVID-19 vaccines. You can get information and vaccination locations at vaccine.coronavirus.ohio.gov/ or by calling ODH toll-free at 833-427-5634.

Molina Dual Options MyCare Ohio can help you find a testing or vaccination location in your community. They also can help with scheduling and transportation to your appointment. Use the information at the bottom of the page to contact Molina Dual Options MyCare Ohio Member Services or the Nurse Advice Hotline at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

ODH gives regular updates on vaccination eligibility phases at coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program.

B . Rules against providers charging you for services

Except as indicated above, we do not allow Molina Dual Options MyCare Ohio providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a covered service.

You should never get a bill from a provider for a covered service. If you do, refer to Chapter 7 or call Member Services.

C. Our plan's Benefits Chart

The following Benefits Chart in Section D is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your care manager.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
    - If Molina Dual Options MyCare Ohio makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, refer to Chapter 9.

- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to get the service. If you are not sure whether a service requires PA, contact Member Services or visit our website at www.MolinaHealthcare.com/Duals.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

D. The Benefits Chart

D1. Preventive Visits

Services covered by our plan	Limitations and exceptions
Annual checkup This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months. **Note**: You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	
"Welcome to Medicare" visit If you have been in Medicare Part B for 12 months or less, you can get a one-time "Welcome to Medicare" preventive visit. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. This visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), and • referrals for other care if you need it.	
Well child check-up (also known as Healthchek) Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.	

D2. Preventive Services and Screenings

Services covered by our plan	Limitations and exceptions
Abdominal aortic aneurysm screening The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk.	
Alcohol misuse screening and counseling The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner.	
Breast cancer screening The plan covers the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and older • women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms • annual clinical breast exams	
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may: • discuss aspirin use, • check your blood pressure, or • give you tips to make sure you are eating well.	
Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.	
Cervical and vaginal cancer screening The plan covers pap tests and pelvic exams annually for all women.	

Services covered by our plan	Limitations and exceptions
Colorectal cancer screening The plan will pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	

Services covered by our plan	Limitations and exceptions
Counseling and interventions to stop smoking or tobacco use The plan covers tobacco cessation counseling and intervention. The plan offers 8 counseling sessions to stop smoking or tobacco use in addition to your Medicare benefit.	
Depression screening The plan covers depression screening.	
Diabetes screening The plan covers diabetes screening (includes fasting glucose tests). You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).	
HIV screening The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.	
Immunizations The plan covers the following services: • vaccines for children under age 21 • pneumonia vaccine • flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you are at risk and they meet Medicare Part B or Medicaid coverage rules • other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more.	

Services covered by our plan	Limitations and exceptions
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	
Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	
Obesity screening and therapy to keep weight down The plan covers counseling to help you lose weight.	
Prostate cancer screening The plan covers the following services: • a digital rectal exam • a prostate specific antigen (PSA) test	
Sexually transmitted infections (STIs) screening and counseling The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B. The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.	

D3. Other Services

Services covered by our plan	Limitations and exceptions
Acupuncture The plan covers acupuncture for pain management of headaches, lower back pain, neck pain, osteoarthritis of the hip or knee, nausea or vomiting related to pregnancy or chemotherapy, and acute post-operative pain. The plan will also pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; and • not associated with pregnancy. The plan will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments each year for chronic low back pain. Once the Medicare limit is reached, services for chronic low back pain are covered by Medicaid when medically necessary, up to 10 additional treatments. Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.	Authorization is required for more than 30 acupuncture visits per benefit year. Some acupuncture services may need prior authorization. If you need help finding an acupuncture provider, ask your doctor for a referral.

Services covered by our plan	Limitations and exceptions
Ambulance and wheelchair van services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or, if you are pregnant, your unborn baby's life or health. In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.	Prior authorization is required for non-emergent ambulance only. Air Ambulance services may need prior authorization for non-emergency care.
Behavioral health services at addiction treatment centers The plan covers the following services at addiction treatment centers: • Ambulatory detoxification • Assessment • Case management • Counseling • Crisis intervention • Intensive outpatient • Alcohol/drug screening analysis/lab urinalysis • Medical office visit with your doctor • Methadone administration • Medication Assisted Treatment (MAT) for addiction • Residential treatment services **See "Inpatient behavioral health services" and "Outpatient mental health care" for more information.**	Some behavioral health services need prior authorization. If a network provider is not available in your area, the non-network provider may need prior authorization. They must ask for prior authorization for all services immediately following the first office visit.

Services covered by our plan	Limitations and exceptions
Behavioral health treatment services at community mental health centers The plan covers the following services at certified community mental health centers: • Mental health assessment/diagnostic psychiatric evaluation • Assertive Community Treatment (ACT) • Intensive Home Based Treatment (IHBT) • Screening, Brief Intervention and Referral to Treatment (SBIRT) • Psychological Testing • Therapeutic Behavioral Services (TBS) • Psychosocial Rehabilitation • Community psychiatric supportive treatment (CPST) services • Counseling and therapy • Crisis intervention • Pharmacological management • Certain office administered injectable antipsychotic medications • Partial hospitalization for Substance Use Disorder only Partial hospitalization is a structured program of active substance use disorder treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. See "Inpatient behavioral health services" and "Outpatient mental health care" for more information. Members with complex behavioral health needs, between the ages of 18 and 21, may qualify for additional behavioral health services through Ohio's Resilience through Integrated Systems and Excellence (OhioRISE) program. Speak to your treatment provider for more information. For more information on OhioRISE services, please contact Aetna Better Health of Ohio member services at (833) 711-0773.	Some behavioral health services need prior authorization. If a network provider is not available in your area, the non-network provider must get prior authorization. They must ask for prior authorization for all services immediately following the first office visit.

Services covered by our plan	Limitations and exceptions
Chiropractic services The plan covers: • diagnostic x-rays • adjustment of the spine to correct alignment	The plan covers up to 15 visits in each 12-month period for members age 21 and older. Prior authorization is needed for more than 15 visits. The plan covers up to 30 visits in each 12-month period for members age 20 and younger. Prior authorization is needed for more than 30 visits.
Dental services The plan offers comprehensive dental benefits. The plan covers the following services: • comprehensive oral exam (one per provider-patient relationship) • periodic oral exam once every 6 months for all members • Dental cleaning once every 6 months for all members • preventive services including prophylaxis, fluoride for members under age 21 (once every 180 days), sealants, and space maintainers • routine radiographs/diagnostic imaging (X-rays) • comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services • Dental X-rays are covered twice annually • Visit the www.MolinaHealthcare.com/Duals website for additional information about your dental benefits. • We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	Dental services other than routine care need prior authorization. Call Member Services for more information. The number is on the back of your ID card.

Services covered by our plan	Limitations and exceptions
Diabetic services The plan covers the following services for all people who have diabetes (whether they use insulin or not): • training to manage your diabetes, in some cases • supplies to monitor your blood glucose, including: ○ blood glucose monitors and test strips ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors • for people with diabetes who have severe diabetic foot disease: ○ one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan also covers fitting the therapeutic custom-molded shoes or depth shoes.	Some services may need prior authorization. Prior authorization may be needed for some glucose meters and test strips. Check with your pharmacy or Member Services if you have questions. Extra shoes or shoe inserts may need prior authorization.

Services covered by our plan	Limitations and exceptions
Durable medical equipment (DME) and related supplies Covered DME includes, but is not limited to, the following: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps • speech generating devices • oxygen equipment and supplies • nebulizers • walkers Other items (such as incontinence garments, enteral nutritional products, ostomy and urological supplies, and surgical dressings and related supplies) may be covered. For additional types of supplies that the plan covers, refer to the sections on diabetic services, hearing services, and prosthetic devices. The plan may also cover learning how to use, modify, or repair your item. Your care team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan. We will cover all DME that Medicare and Medicaid usually cover. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. You can get some DME items under $30 at pharmacies in the Molina Dual Options MyCare Ohio network at no cost. You must have a prescription. Call your Molina Care Manager or Member Services to learn more.	Prior authorization may be needed for certain durable medical equipment (DME) items. Your doctor will need to check the list of DME items that need prior authorization before you can get the item. The list can be found on Molina Dual Options MyCare Ohio's provider website.

Services covered by our plan	Limitations and exceptions
Emergency care (refer to also "urgently needed care") Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or if pregnant, to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part; **or** • in the case of a pregnant woman in active labor, when: o there is not enough time to safely transfer you to another hospital before delivery. o a transfer to another hospital may pose a threat to your health or to that of your unborn child. In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do. 988 is the Suicide & Crisis Lifeline, providing 24/7, free and confidential support to people in suicidal crisis or emotional distress. Call or text the number 988 or chat at 988lifeline.org to talk to a trained crisis counselor. Emergency care is not covered outside the U.S. and its territories except under limited circumstances. Contact Member	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, the hospital must contact Molina Dual Options MyCare Ohio Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time to get prior authorization for the post-stabilization care.

Services covered by our plan	Limitations and exceptions
Services for details. **Family planning services** The plan covers the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (birth control pills, patch, ring, IUD, injections, implants) • family planning supplies (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility, and related services • counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • treatment for sexually transmitted infections (STIs) • treatment for AIDS and other HIV-related conditions • voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) **Note:** You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the *Provider and Pharmacy Directory*. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider.	

Services covered by our plan	Limitations and exceptions
Federally Qualified Health Centers The plan covers the following services at Federally Qualified Health Centers: • office visits for primary care and specialist services • physical therapy services • speech pathology and audiology services • dental services • podiatry services • optometric and/or optician services • chiropractic services • transportation services • mental health services **Note:** You can get services from a network or out-of-network Federally Qualified Health Center.	Prior authorization is not needed for most services.
Fitness Benefit: The Silver&Fit® Program You get access to a fitness program, with options to meet your exercise needs. Through the Silver&Fit program, you get access to: • The Get Started program, an online program to help you begin working out or move to the next level of fitness activity. Get Started provides a personalized exercise plan based on your fitness interests, including a list of digital workout videos. • Fitness centers in the Silver&Fit network. If needed, you can bring your caregiver with you to the fitness center. • One Home Fitness Kit per calendar year, mailed to your door. Kit options include Wearable Fitness Tracker Kits, Strength Kits, Yoga Kits, Swim Kits and a Pilates Kit. • A library of workout videos, which has over 8,000 digital videos on the website and mobile app. • Other wellness resources like Healthy Aging classes, a newsletter and rewards for reaching your goals. **This benefit is continued on the next page**	

Services covered by our plan	Limitations and exceptions
Fitness Benefit: The Silver&Fit® Program (continued) • Online, live workout classes on Facebook and YouTube. The Silver&Fit program offers 9 exercise classes a day, 6 days a week. • Healthy Aging Coaching over the phone. Get help with exercise, nutrition, stress, emotional wellness and more. There are two ways to start using your Silver&Fit benefit: • Go to SilverandFit.com. Register to use the website. After registering, you can use the Get Started program to get your personal exercise plan. Use the website to find a fitness center, watch workout videos online, and select a Home Fitness Kit. • Call Member Services at (855) 665-4623 or TTY 711, Monday – Friday, 8 a.m. – 8 p.m. local time. *Non-standard services that call for an added fee are not part of the Silver&Fit program and will not be reimbursed. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein. Participating facilities and fitness chains may vary by location and are subject to change. Kits and rewards are subject to change.	
Freestanding Birth Center The plan covers freestanding birth center services at a freestanding birth center. Call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time to see if there are any qualified centers in your area.	

Services covered by our plan	Limitations and exceptions
Health and wellness education programs These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. • Health Management programs and Health Education o If you have trouble with a medical condition that needs extra attention, we have programs that focus on asthma, diabetes, heart disease and Chronic Obstructive Pulmonary Disease (COPD). o These programs are offered at no cost to you. They include learning materials and care tips. • Diet and Nutrition Education Benefit • 24-Hour Nurse Advice Line and Behavioral Health Crisis Line • Remote Access Technologies o View your care plan or message your Care Manager online with My Molina. o Get self-service features on your phone with the My Molina mobile app, available now on iOS and Android. Call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time to enroll or learn more.	The plan covers 12 nutritional counseling sessions over the phone, between 30 - 60 minutes each. Individual nutrition counseling over the phone is available upon request. Prior authorization is needed after the first 12 counseling sessions.
Hearing services and supplies The plan covers the following: • hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider) • hearing aids, batteries, and accessories (including repair and/or replacement) o conventional hearing aids are covered once every 4 years o digital/programmable hearing aids are covered once every 5 years	Some hearing aids may need prior authorization. Two hearing aids may be considered in special circumstances.

Services covered by our plan	Limitations and exceptions
Home and community-based waiver services The plan covers the following home and community-based waiver services: • adult day health services • alternative meals service • assisted living services • choices home care attendant • community integration services • community transition • enhanced community living services • home care attendant • home delivered meals • home medical equipment and supplemental adaptive and assistive devices services • home maintenance, and chore services • home modification services • homemaker services • nutritional consultation • out-of-home respite services • personal care aide services • personal emergency response services • social work counseling • waiver nursing services • waiver transportation	Waiver services must be approved by your Waiver Services Coordinator or Care Manager. These services are available only if your need for long-term care has been determined by Ohio Medicaid. You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. All home and community-based waiver services need prior authorization.

Services covered by our plan	Limitations and exceptions
Home health services The plan covers the following services provided by a home health agency: • home health aide and/or nursing services • physical therapy, occupational therapy, and speech therapy • private duty nursing (may also be provided by an independent provider) • home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally • medical and social services • medical equipment and supplies	Some home health services may need prior authorization.
Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	Prior authorization is required.

Services covered by our plan	Limitations and exceptions
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following while you are getting hospice services: • drugs to treat symptoms and pain • short-term respite care • home care • nursing facility care **Hospice services and services covered by Medicare Part A or B are billed to Medicare:** • Refer to Section F of this chapter for more information. **For services covered by Molina Dual Options MyCare Ohio but not covered by Medicare Part A or B:** • Molina Dual Options MyCare Ohio will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services. **For drugs that may be covered by Molina Dual Options MyCare Ohio's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. **Note:** Except for emergency/urgent care, if you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Please call (855) 895-9986, TTY: 711, 24 hours a day, 7 days a week.	If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Hospice care in a nursing facility requires prior authorization. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

Services covered by our plan	Limitations and exceptions
Inpatient behavioral health services The plan covers the following services: • inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital ○ For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit • inpatient detoxification care	The plan must be notified within 24 to 48 hours of admission. The plan covers an unlimited number of days for an inpatient stay for medically necessary inpatient care. The 190-day lifetime limit for inpatient psychiatric care is a Medicare coverage limit. Inpatient psychiatric care is covered by Medicaid when medically necessary after the Medicare coverage limit is reached.

Services covered by our plan	Limitations and exceptions
Inpatient hospital care The plan covers the following services, and maybe other services not listed here: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • x-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs for use in the hospital • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance use disorder services • blood, including storage and administration • physician/provider services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If Molina Dual Options MyCare Ohio provides transplant services at a distant location outside the pattern of care for your community and you choose to get your transplant there, we will arrange or cover lodging and travel costs for you and one other person. If a transplant was approved and scheduled before you joined our plan, Molina Dual Options MyCare Ohio must cover the transplant.	Inpatient hospital care needs prior authorization.

Services covered by our plan	Limitations and exceptions
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If your inpatient stay is not reasonable and necessary, the plan will not cover it. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • x-ray, radium, and isotope therapy, including technician materials and services • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: o replace all or part of an internal body organ (including contiguous tissue), or o replace all or part of the function of an inoperative or malfunctioning internal body organ. • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition • physical therapy, speech therapy, and occupational therapy	Some inpatient services may need prior authorization.

Services covered by our plan	Limitations and exceptions
Kidney disease services and supplies The plan covers the following services: • kidney disease education services to teach kidney care and help you make good decisions about your care • outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible • inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • home dialysis equipment and supplies • certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Note:** Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please refer to "Medicare Part B prescription drugs" in this chart.	
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan covers three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that. Services from a registered dietician are covered when there is a supervising physician.	Prior authorization is not needed when services are performed in a network provider office or freestanding diagnostic center.

Services covered by our plan	Limitations and exceptions
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Molina Dual Options MyCare Ohio covers the following drugs: • drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • clotting factors you give yourself by injection if you have hemophilia • immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • antigens • certain oral anti-cancer drugs and anti-nausea drugs • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as ProcritÒ, or Epoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases. The following link will take you to a list of Part B drugs that may be subject to step therapy: www.MolinaHealthcare.com/MyCareRx We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.	Prior authorization is needed. Step therapy may be required for certain drugs.

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility (SNF) care The plan covers the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • x-rays and other radiology services given by nursing facilities • durable medical equipment, such as wheelchairs, usually given by nursing facilities • physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived on the day you became a Molina Dual Options MyCare Ohio member You can get Medicare nursing facility care from the following places if they accept our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. Note that patient liability does not apply to Medicare-covered days in a nursing facility. Custodial nursing facility stays do not need prior authorization. All other nursing facility services need prior authorization. Call Member Services to learn more about available providers. The number is on the back of your ID card.

Services covered by our plan	Limitations and exceptions
Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	Some opioid treatment program services may need prior authorization.
Outpatient behavioral health care The plan covers behavioral health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP), • a physician assistant (PA), **or** • any other qualified mental health care professional as allowed under applicable state laws. The plan covers the following services, and maybe other services not listed here: • Clinic services and general hospital outpatient services • Therapeutic Behavioral Services (TBS) • Psychosocial rehab services	Prior authorization is not needed for most outpatient behavioral health services from the network providers listed under this benefit. If a network provider is not available in your area, the non-network provider may need to get prior authorization. They must ask for prior authorization for all services immediately following the first office visit.

Services covered by our plan	Limitations and exceptions
Outpatient services The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury. The following are examples of covered services: • services in an emergency department or outpatient clinic, such as outpatient surgery or observation services o Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." o Sometimes you can be in the hospital overnight and still be an "outpatient." o You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101 • the plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers* • chemotherapy • labs and diagnostic tests (for example urinalysis) • mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it* • imaging (for example x-rays, CTs, MRIs)* • radiation (radium and isotope) therapy, including technician materials and supplies* • blood, including storage and administration* • medical supplies, such as splints and casts* • preventive screenings and services listed throughout the Benefits Chart • some drugs that you can't give yourself	Some services need prior authorization. (*) – denotes prior authorization may be needed for certain services.

Services covered by our plan	Limitations and exceptions
Over-the-counter (OTC) items You get $60 every quarter to spend on plan-approved OTC items. Your coverage includes non-prescription OTC health and wellness items. This includes items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages. You can order: • **Online –** Visit NationsOTC.com/Molina. • **By Phone –** Call Member Services at (855) 665-4623 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m., local time. • **By Mail –** Fill out and return the order form in the OTC Product Catalog • **By Debit Card/Retail –** You may use an OTC Debit Card to purchase approved OTC products at any retail store. Call an OTC support person toll-free at (866) 420-4010 (TTY/TDD: 711) to request an OTC Debit Card. Your OTC Debit Card, along with activation instructions, will be mailed to you. Refer to your 2024 OTC Product Catalog for a complete list of plan-approved OTC items or call Member Services for more information. You will find important information (order guidelines) in the 2024 OTC Product Catalog.	You have $60 every quarter to spend on plan-approved OTC items. A quarter, or quarterly period, lasts 3 months. Quarterly periods for your covered OTC benefit are: January to March April to June July to September October to December The $60 you get every quarter expires at the end of the quarterly period. It does not roll over to the next quarterly period, so be sure to spend any unused amount before the end of the quarter.
Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	

Services covered by our plan	Limitations and exceptions
Physician/provider services, including doctor's office visits The plan covers the following services: • health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department • consultation, diagnosis, and treatment by a specialist • Certain additional telehealth coverage, including primary care services.* You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • To find a provider that offers telehealth services, use the Provider and Pharmacy Directory, visit us online at MolinaHealthcare.com/Duals, or call Member Services. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ you have an in-person visit within 6 months prior to your first telehealth visit ○ you have an in-person visit every 12 months while receiving these telehealth services ○ exceptions can be made to the above for certain circumstances **This benefit is continued on the next page.**	Some services need prior authorization. Non-routine dental care requires prior authorization. Additional telehealth services do not require prior authorization. If no network provider is available for a second opinion, the plan will cover a second opinion by a non-network provider.

Services covered by our plan	Limitations and exceptions
Physician/provider services, including doctor's office visits (continued) • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o you're not a new patient and o the check-in isn't related to an office visit in the past 7 days and o the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: o you're not a new patient and o the evaluation isn't related to an office visit in the past 7 days and o the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • non-routine dental care.* Covered services are limited to: o surgery of the jaw or related structures, o setting fractures of the jaw or facial bones, o pulling teeth before radiation treatments of neoplastic cancer, or o services that would be covered when provided by a physician. Virtual medical visits give you care at home or wherever you are, without going to the doctor's office. You get virtual medical care from network providers using online technology and live audio or video. Note: Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment.	

Services covered by our plan	Limitations and exceptions
Podiatry services The plan covers the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma • routine foot care for members with conditions affecting the legs, such as diabetes	Office visits for examination and plan of care do not need prior authorization. In-office podiatry procedures and interventions need prior authorization.
Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. The following are examples of covered prosthetic devices: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) • dental devices The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. Refer to "Vision Care" later in this section for details.	Some devices and supplies need prior authorization.

Services covered by our plan	Limitations and exceptions

Rehabilitation services
• outpatient rehabilitation services
  ○ The plan covers physical therapy, occupational therapy, and speech therapy.
  ○ You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.
• cardiac (heart) rehabilitation services
  ○ The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions.
  ○ The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.
• pulmonary rehabilitation services
  ○ The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).
	Some rehabilitation services need prior authorization.

Rural Health Clinics The plan covers the following services at Rural Health Clinics: • office visits for primary care and specialist services • clinical psychologist • clinical social worker for the diagnosis and treatment of mental illness • visiting nurse services in certain situations **Note:** You can get services from a network or out-of-network Rural Health Clinic.	

Services covered by our plan	Limitations and exceptions
Specialized Recovery Services (SRS) Program If you are an adult who has been diagnosed with a severe and persistent mental illness and you live in the community, you may be eligible to get SRS specific to your recovery needs. The plan covers the following three services if you are enrolled in the SRS program: • Recovery Management – Recovery managers will work with you to: o develop a person-centered care plan which reflects your personal goals and desired outcomes, o regularly monitor your plan through regular meetings, and o provide information and referrals. • Individualized Placement and Support-Supported Employment (IPS-SE) – Supported employment services can: o help you find a job if you are interested in working, o evaluate your interests, skills, and experiences as they relate to your employment goals, and o provide ongoing support to help you stay employed. • Peer Recovery Support: o peer recovery supporters use their own experiences with mental health and substance use disorders to help you reach your recovery goals, and o goals are included in a care plan you design based on your preferences and the availability of community and supports. The peer relationship can help you focus on strategies and progress towards self-determination, self-advocacy, well-being and independence.	If you are interested in SRS, you will be connected with a recovery manager who will begin the assessment for eligibility looking at things such as your diagnosis and your need for help with activities such as medical appointments, social interactions and living skills.

Services covered by our plan	Limitations and exceptions
Supervised exercise therapy (SET)* The plan will pay for SET for members with symptomatic peripheral artery disease (PAD). The plan will pay for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	

Services covered by our plan	Limitations and exceptions
Transportation for non-emergency services (also refer to "Ambulance and wheelchair van services") ***An extra 30 one-way trips – an extra benefit just for Molina Dual Options MyCare Ohio members.*** You get an extra transportation benefit. You get an extra 30 one-way trips every calendar year. These trips will get you to and from places where you get covered health care services. This includes non-emergency trips to the doctor, dentist, hospital, pharmacy, Medicaid renewal visits, and more. You may also use your extra benefit of 30 one-way trips for: • Supplemental Security Income (SSI) appointments • Community Mental Health Services appointments • Women, Infants and Children (WIC) appointments • Food resources, such as the grocery store or food bank • Pharmacy visits for medications or other needs In addition to the 30 one-way trips, transportation is always covered for members who get these services: • Dialysis • Chemotherapy • Radiation • Wheelchair transports. You can always get a ride if you must travel more than 30 miles to get covered medical services. These rides are unlimited, but only if there is not a provider closer to your home. You can always get a ride if you are discharged from the hospital. Hospital discharges include emergency room, inpatient and outpatient discharges. To schedule transportation services, call (844) 491-4761 (TTY: 711) at least 2 business days before your visit. If you need to cancel transportation you have scheduled, call (844) 491-4761 (TTY: 711) to let us know. Let us know 24 hours before your visit. If you do not call to cancel 24 hours before your visit, the ride may count as one of your 30 trips for the year. **This benefit is continued on the next page.**	Some transportation services may need health plan approval.

Services covered by our plan	Limitations and exceptions
Transportation for non-emergency services (continued) You can also schedule and manage transportation services with the Access2Care mobile app. Visit the iPhone App Store or Google Play and search "A2C" to download. Find out more about your transportation benefits in Chapter 3 of this book. Note: In addition to the transportation assistance that Molina Dual Options MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.	
Transitional Meal Benefit This program is uniquely designed to keep you healthy and strong while you are recovering after an inpatient hospital stay or Skilled Nursing Facility (SNF) stay. You may also use this benefit if you must stay at home for a period of time because of a medical condition or potential medical condition. If you qualify, your plan Care Manager will enroll you in the program. You may also qualify if your doctor requests this benefit for you because of your chronic condition. The initial benefit provides 14 days of meals, which includes 2 meals a day. With additional approval, you may get another 14 days of meals, which includes 2 meals a day. The maximum benefit amount is 28 days (4 weeks) of meals each year, up to a total of 56 meals.	*Service Authorization Form needed.*

Services covered by our plan	Limitations and exceptions
Urgently needed care Urgently needed care is care given to treat: • a non-emergency, or • a sudden medical illness, or • an injury, or • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for unseen condition but it not a medical emergency. To find an urgent care center near you, view our searchable online provider directory at www.MolinaHealthcare.com/Duals. Not covered outside the U.S. and its territories except under limited circumstances. Contact Member Services for details.	

Services covered by our plan	Limitations and exceptions
Vision care • The plan covers the following services: • one comprehensive eye exam and one pair of eyeglasses (eyeglass lenses and frames), one pair of lenses, one frame, or one pair of contact lenses: o Every 12 months for members age 18 to 20, and age 60 and older; or o Every 24 months for members ages 21 to 59. • vision training • services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: o annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration o One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, members with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 and older. o One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also cover corrective lenses and frames. The plan will cover replacements if you need them after a cataract removal without a lens implant. o The plan also offers an expanded selection of frames to choose from at no cost to you.	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. You can only be billed by your vision care provider if you agree to pay for the service and sign a written statement before getting the service. If you get a bill from a provider you did not agree to pay, call Member Services.

E . Services when you are away from home or outside of the service area

If you are away from home or outside of our service area (refer to Chapter 1) and need medical care in an emergency, go to the nearest emergency department. You have the right to go to any facility that provides emergency services. Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor. Emergency care is not covered outside the U.S.

F. Benefits covered outside of Molina Dual Options MyCare Ohio

The following services are not covered by Molina Dual Options MyCare Ohio but are available through Medicare. Call Member Services to find out about services not covered by Molina Dual Options MyCare Ohio but available through Medicare.

F1. Hospice Care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Molina Dual Options MyCare Ohio pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by Molina Dual Options MyCare Ohio's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5.

Note: If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

G. Benefits not covered by Molina Dual Options MyCare Ohio, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not cover these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this Member Handbook) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary, and Medicare covers it.
- A private room in a hospital, except when it is medically necessary.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Inpatient hospital custodial care.
- Full-time nursing care in your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.

- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Infertility services for males or females.
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Paternity testing.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Services to find cause of death (autopsy).

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.

Molina Dual Options MyCare Ohio also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care *provider* (PCP). It could also be another provider.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on the plan's List of Covered Drugs. We call it the "Drug List" for short.
    - If it is not on the Drug List, we may be able to cover it by giving you an exception.
    - Refer to Chapter 9 to learn about asking for an exception.
5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions only if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services *or your Care Manager*.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, show your Member ID Card at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If you need help getting a prescription filled, you can contact Member Services or our 24-Hour Nurse Advice Call Line*, or your Care Manager*.

A3. What to do if you change a prescription to a different network pharmacy

If you change pharmacies and need a refill of a prescription, you can *either ask to have a new prescription written by a provider or* ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help finding a network pharmacy, you can contact Member Services *or your Care Manager*.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services *or your Care Manager*.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.

- Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
- If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services *or your Care Manager*.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List. The drugs that are not available through the plan's mail-order service are marked with **NM** in our Drug List.

Our plan's mail-order service allows you to order at least a 30-day supply of the drug and no more than a 90-day supply. A 90-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or you can visit www.MolinaHealthcare.com/Duals.

Usually, a mail-order prescription will get to you within 14 days. Please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time if your mail-order is delayed.

Mail-order processes

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. New prescriptions the pharmacy gets from you

The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. New prescriptions the pharmacy gets directly from your provider's office

After the pharmacy gets a prescription from a health care provider, it will contact you to find out if you want the medication filled immediately or at a later time.

- This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped.
- It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

  To opt out of our program that automatically prepares mail-order refills, please contact us by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. The pharmacy will contact you by phone at the number you have provided. It is important to make sure that your pharmacy has the most current contact information.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The Provider and Pharmacy Directory tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If the prescription is related to urgently needed care
- If these prescriptions are related to care for a medical emergency
- Coverage will be limited to a 31-day supply unless the prescription is written for less

In these cases, please check first with Member Services to find out if there is a network pharmacy nearby.

If you use an out-of-network pharmacy, you may have to pay the full cost when you get your prescription.

If you were unable to use a network pharmacy and had to pay for your prescription, refer to Chapter 7.

B. The plan's Drug List

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs and items covered under your Medicaid benefits.

The Drug List includes brand name drugs, generic drugs, and biosimilars. A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs or biological products and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.MolinaHealthcare.com/Duals. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.Caremark.com or call Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition

Ask your Care Manager to find out if a drug is on the plan's Drug List.

B3. Drugs that are not on the Drug List

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Molina Dual Options MyCare Ohio will not pay for the drugs listed in this section. These are called excluded drugs. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Molina Dual Options MyCare Ohio for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of three (3) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1 drugs are generic drugs. For Tier 1 drugs, you pay nothing.
- Tier 2 drugs are brand name drugs. For Tier 2 drugs, you pay nothing.
- Tier 3 drugs are Non-Medicare Rx/Over-The-Counter (OTC) drugs. For Tier 3 drugs, you pay nothing.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

Chapter 6 tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9.

Prior authorization (PA) – certain criteria must be met before a drug is covered. For example, diagnosis, lab values, or previous treatments tried and failed.

Step therapy (ST) – Certain cost-effective drugs must be used before other more expensive drugs are covered. For example, certain brand-name medications will only be covered if a generic alternative has been tried first.

Quantity limit (QL) – Certain drugs have a maximum quantity that will be covered. For example, certain drugs that are approved by the FDA to be taken once daily may have a quantity limit of #30 per 30 days.

B vs. D – Some drugs may be covered under Medicare part D or B, depending on the circumstances.

1. Limiting use of a brand name drug or original biological products when a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. If there is a generic or interchangeable biosimilar version of a brand name drug or original biological product, our network pharmacies will give you the generic or interchangeable biosimilar version.

- We usually will not pay for the brand name drug or original biological product when there is a generic version.
- However, if your provider has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Molina Dual Options MyCare Ohio before you fill your prescription. If you don't get approval, Molina Dual Options MyCare Ohio may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at www.MolinaHealthcare.com/Duals.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new, and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:
   - is no longer on the plan's Drug List, or
   - was never on the plan's Drug List, or
   - is now limited in some way.

2. You must be in one of these situations:
   - You were in the plan last year.
     - We will cover a temporary supply of your **drug during the first 90 days of the calendar year.**
     - This temporary supply will be for up to 31 days.
     - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You are new to the plan.
     - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**

- This temporary supply will be for up to 31 days.
- If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You have been in the plan for more than 90 and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
  - We will cover a 31-day supply, or less if your prescription is for fewer days, if you are a new resident of a long-term care facility. Members should seek a formulary exception during this time. Exceptions can be made when you have a change in your level of care that also requires you to move from one treatment center to another. In these cases, you would be able to get a temporary, one-time fill exception. This is for Medicare Part D covered drugs only and does not apply to Medicaid covered drugs. Drugs must be bought at a network pharmacy.
  - To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

  You can ask for an exception.

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9.

If you need help asking for an exception, you can contact Member Services or your Care Manager.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but Molina Dual Options MyCare Ohio may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior authorization (PA) or approval for a drug. (PA is permission from Molina Dual Options MyCare Ohio before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the beginning of the year, we will generally not remove or change coverage of that drug during the rest of the year unless:

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, or
- we learn that a drug is not safe, or
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check Molina Dual Options MyCare Ohio's up to date Drug List online at www.MolinaHealthcare.com/Duals or
- Call Member Services to check the current Drug List at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

Some changes to the Drug List will happen immediately. For example:

- **A new generic drug or interchangeable biosimilar becomes available.** Sometimes, a new generic drug or an interchangeable biosimilar version of the same biological product comes on the market that works as well as a brand name drug or original biological product on the Drug List now. When that happens, we may remove the brand name drug or original biological product and add the new generic drug or an interchangeable biosimilar version of the same biological product, but your cost for the new drug or an interchangeable biosimilar will stay the same.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. Contact your prescribing doctor if you receive a notification.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market and
  - Replace a brand name drug currently on the Drug List or
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List or
- Let you know and give you a 31-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead or
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9.

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the beginning of the year, we generally will not remove or change coverage of that drug during the rest of the year.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

F2. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your Provider and Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require certain drugs (e.g., a pain medication, anti-nausea drugs, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify.

If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Member Services or your Care Manager.

G3. Drug management program to help members safely use their opioid medications

Molina Dual Options MyCare Ohio has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from certain pharmacies and/or from certain doctors**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, or
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

Introduction

This chapter tells you about your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, and
- drugs and items covered under Medicaid

Because you are eligible for Medicaid, you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- The plan's *List of Covered Drugs*.
    - We call this the "Drug List." It tells you:
        - Which drugs the plan pays for
        - Which of the three (3) tiers each drug is in
        - Whether there are any limits on the drugs
    - If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at www.MolinaHealthcare.com/Duals. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.
    - Chapter 5 tells how to get your outpatient prescription drugs through the plan.
    - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.

- The plan's *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call Member Services for more information.

Table of Contents

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.
- **Drug price information.** This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- To find out which drugs our plan covers, refer to the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, and that Medicare pays for you, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill, what you pay, and what Medicare pays for you.

2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you have paid for. You should give us copies of your receipts when you buy covered drugs at an out-of-network pharmacy.

If you were unable to use a network pharmacy and had to pay for your prescription, refer to Chapter 7 for information about what to do.

3. Check the EOBs we send you.

When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing or if you have any questions, please call Member Services. Be sure to keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With Molina Dual Options MyCare Ohio, you pay nothing for covered drugs as long as you follow the plan's rules.

C1. The plan's tiers

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of three (3) tiers. You have no copays for prescription and OTC drugs on Molina Dual Options MyCare Ohio's Drug List. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are generic drugs. For Tier 1 drugs, you pay nothing.
- Tier 2 drugs are brand name drugs. For Tier 2 drugs, you pay nothing.
- Tier 3 drugs are Non-Medicare Rx/Over-The-Counter (OTC) drugs. For Tier 3 drugs, you pay nothing.

C2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 or the Provider and Pharmacy Directory.

C3. What you pay

	A network pharmacy A one-month or up to a 100-day supply	The plan's mail-order service A one-month or up to a 100-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy Up to a 31-day supply. Coverage is limited to certain cases. Refer to Chapter 5 for details.
Tier 1 (Generic drugs)	$0	$0	$0	$0
Tier 2 (Brand name drugs)	$0	$0	$0	$0
Tier 3 (Non-Medicare Rx/Over-The-Counter (OTC) drugs)	$0	$0	$0	$0

For information about which pharmacies can give you long-term supplies, refer to the plan's Provider and Pharmacy Directory.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered (Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself.** The vaccine is a prescription drug.
1. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

COVID-19 Vaccinations

There is no cost for you to get a COVID-19 vaccine. The vaccines are safe and effective, and can help prevent serious illness, hospitalization and death from COVID-19. For more information about the COVID-19 vaccine, see Chapter 4.

D1. What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with Molina Dual Options MyCare Ohio to ensure that you do not have any upfront costs for a Part D vaccine.

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.

Table of Contents

A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, call Member Services or send the bill to us. To send us a bill, refer to page 119.

- If you have not paid the bill, we will pay the provider directly if the services or drugs are covered and you followed all the rules in the Member Handbook.
- If you have paid, the services or drugs are covered, and you followed all the rules in the Member Handbook, it is your right to be paid back.
- If the services or drugs are not covered, we will tell you.

Contact Member Services or your Care Manager if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are some examples of times when you may need to ask our plan to assist you with a payment you made or a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should always tell the provider you are a member of Molina Dual Options MyCare Ohio and ask the provider to bill the plan.

- If you pay the full amount when you get the care, you can ask to have the full amount refunded. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
    - If the provider should be paid, we will pay the provider directly.
    - If you have already paid for the service, we will work with the provider to refund your payment.

2. When a network provider sends you a bill

Network providers must always bill the plan for covered services. Show your Molina Dual Options MyCare Ohio Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- Because Molina Dual Options MyCare Ohio pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will work with the provider to refund your payment amount for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled in an emergency situation

- We will cover prescriptions filled at out-of-network pharmacies in emergency situations only.

The prescription drug must be related to urgently needed care or care for a medical emergency.

Coverage will be limited to a 31-day supply unless the prescription is written for less.

Molina Dual Options MyCare Ohio will reimburse you for coverage charges on Part D drug expenses incurred at out-of-network pharmacies or providers in the following situations:

- You travel outside your Part D plan's service area; you run out of or lose your covered Part D drug(s) or become ill and need a covered Part D drug; and you cannot access a network pharmacy.
- You must fill a prescription for a covered Part D drug in a timely way, and that drug is not often stocked at accessible network retail or mail-order pharmacies.
- You cannot get a covered Part D drug in a timely way within your service area. For example, there is no network pharmacy within a reasonable driving distance that provides services 24 hours a day, 7 days a week.
- You are given covered Part D drugs by an out-of-network, institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.
- You have been evacuated or otherwise displaced from your home because of a State or Federal disaster declaration, or other public health emergency declaration, and you cannot reasonably be expected to get Part D drugs at a network pharmacy.
- You get a vaccine that is medically necessary but is not covered by Medicare Part B. The vaccine must be properly dispensed and administered in a physician's office.
- Molina Dual Options MyCare Ohio may also use out-of-network policies to help you get covered Part D drugs in other situations not listed here, if you cannot get your Part D drugs the way you normally would.
- Before getting covered Part D drugs through an out-of-network pharmacy, it is your responsibility to contact Member Services to find a network pharmacy in your area where you can fill the prescription.

- Unless dispensed as a transition or emergency supply, you or your prescriber must check that our plan gave prior authorization if utilization management controls apply to the medication. If our plan did not give prior authorization for you to get the medication, you will not be reimbursed for the medication.

You can always contact Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or your Care Manager at (855) 665-4623, TTY: 711, 24 hours a day, 7 days a week if you are being asked to pay for services, get a bill, or have any questions. You can use the form on page 189 or ask Member Services to send you a form if you want to send us the information about the bill. You can also submit the information through our website at www.MolinaHealthcare.com/Duals.

B. How to avoid payment problems

1. Always ask the provider if the service is covered by Molina Dual Options MyCare Ohio.

Except in an emergency or urgent situation, do not agree to pay for a service unless you have asked Molina Dual Options MyCare Ohio for a coverage decision (refer to Chapter 9), got a final decision that the service is not covered, and decided that you still want the service even though the plan does not cover it.

2. Get plan approval before going to an out-of-network provider.

- Exceptions to this rule are:
  - if you need out-of-network emergency or urgent care services, or
  - if you get services at Federally Qualified Health Centers, Rural Health Clinics and qualified family planning providers listed in the Provider and Pharmacy Directory.
- If you get care from an out-of-network provider, ask the provider to bill Molina Dual Options MyCare Ohio.
  - If the out-of-network provider is approved by Molina Dual Options MyCare Ohio, you should not have to pay anything.
  - If the out-of-network provider will not bill Molina Dual Options MyCare Ohio and you pay for the service, call Member Services as soon as possible to let us know.
- Please remember that in most situations you must get plan approval before you can use an out-of-network provider. Therefore, unless you need emergency or urgent care, are in your transition of care period, or the provider does not require prior approval (PA) as indicated above, we may not pay for services you get from an out-of-network provider.

  If you have questions about your transition of care period, whether you need approval to use a certain provider, or need help in finding a network provider, call Member Services.

3. Follow the rules in the Member Handbook when getting services.

Refer to Chapter 3 for the rules about getting your health care, behavioral health, and other services. Refer to Chapter 5 for the rules about getting your outpatient prescription drugs.

4. Use the Provider and Pharmacy Directory to find network providers.

If you do not have a Provider and Pharmacy Directory, you can call Member Services to ask for a copy or go online at www.MolinaHealthcare.com/Duals for the most up-to-date information.

5. Always carry your Member ID Card and show it to the provider or pharmacy when getting care.

If you forgot your Member ID Card, ask the provider to visit www.MolinaHealthcare.com/Duals, use the Provider Portal, or call Member Services to verify eligibility. If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Chapter 8: Your rights and responsibilities

Introduction

In this chapter, you will find legal notices that apply to your membership in Molina Dual Options My Care Ohio and your rights and responsibilities as a plan member. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.

Table of Contents

A. Legal notices

A1. Notices about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs and state laws about the Medicaid program. Other federal and state laws may apply too.

A2. Notice about nondiscrimination

Every company or agency that works with Medicare and Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, ancestry, evidence of insurability, gender, gender identity, sexual orientation, genetic information, geographic location within the service area, military status, health status, need for health services, medical history, mental or physical disability, national origin, race, religion, or sex.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights.

  Office for Civil Rights
  United States Department of Health and Human Services
  233 N. Michigan Ave., Suite 240
  Chicago, Illinois 60601

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

A3. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

B. Your right to get services and information in a way that meets your needs

We must ensure that all services are provided to you in a culturally competent and accessible manner. Each year you are in our plan, we must also tell you about the plan's benefits and your rights in a way that you can understand. We will tell you about any changes to the plan. We will also tell you about changes to your covered benefits and services.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio.
    - You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request so you do not need to make separate requests each time we send you information.
    - To get this document in a language other than English, contact the State at (800) 324-8680, TTY: 711, Monday – Friday, 7 a.m. to 8 p.m. and Saturday, 8 a.m. to 5 p.m., local time to update your record with the preferred language. To get this document in an alternate format, contact Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. A representative can help you make or change a standing request. You can also contact your Care Manager for help with standing requests.

If you would like to ask for your new member materials in another language or format, call Member Services. Your new member materials include:

- Member Handbook
- Summary of Benefits
- Annual Notice of Changes
- List of Covered Drugs
- Provider/Pharmacy Directory
- Welcome Letter

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also contact the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call 711.
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Usted tiene derecho a recibir información de una manera que cumpla con sus necesidades

Cada año que usted está en nuestro plan, nosotros debemos informarle acerca de los beneficios del plan y sus derechos de una manera que usted pueda entender. Le informaremos si se realizan cambios al plan. También le informaremos acerca de cambios a sus beneficios y servicios cubiertos.

- Para obtener información de una manera que pueda entenderla, comuníquese con el Departamento de Servicios para Miembros. Nuestro plan de salud cuenta con personal que puede contestar preguntas en diferentes idiomas.
- Nuestro plan también le puede ofrecer materiales en otros idiomas aparte de inglés y en formatos como letra grande, braille o audio.
    - Para hacer una solicitud continua de materiales en un lenguaje diferente al inglés o en un formato alternativo ahora y en el futuro, comuníquese con el Departamento de Servicios para Miembros al (855) 665-4623, TTY al 711, de lunes a viernes, de 8:00 a. m. a 8:00 p. m., hora local.

Si desea recibir sus materiales de bienvenida en español, comuníquese con el Departamento de Servicios para Miembros. Le podemos enviar los siguientes materiales en español:

- Manual del miembro
- Resumen de beneficios
- Aviso anual de cambios
- Lista de los medicamentos cubiertos
- Directorio de proveedores y farmacias, y Carta de bienvenida

Si tiene dificultades para obtener información de nuestro plan de salud debido a problemas de idioma o una discapacidad y desea presentar una queja, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Usted puede llamar las 24 horas al día, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede comunicarse a la línea directa de Ohio Medicaid al 1-800-324-8680 de lunes a viernes, de 7:00 a.m. a 8:00 p.m. y los sábados, de 8:00 a.m. a 5:00 p.m. Los usuarios de TTY deben llamar al 7-1-1.

C. Our responsibility to ensure that you get timely access to covered services and drugs

The chart below tells you how long it may take to get care, depending on the type of care you need.

Type of Care Needed	How Long You May Wait to Get Care
Emergency Care (Life-Threatening) These are services for medical problems that you think are so serious that they must be treated right away by a doctor.	You should receive emergency care immediately. Call 911 or go to the nearest emergency department.
Urgent Care, After-Hours Care and Non-Emergency Care Care you get for health problems that cannot wait until your next Primary Care Provider (PCP) visit. This care is for health problems that are not a threat to your life.	At an urgent care center, you should receive care as soon as possible. For after-hours care, you should have access to help 24 hours a day, 7 days a week. For non-emergency care from your PCP, you should receive care by the end of the next business day. For non-emergency care from a specialist or an oncologist, you should receive care within 24 hours.
Routine Care	You should receive care within 6 weeks.
OB/GYN (Reproductive Care for Women) Services	If you are pregnant or believe you may be pregnant, you should have your first visit within 2 weeks. You should receive routine pregnancy care within 6 weeks.
Specialist Care (High-Volume)	You should receive specialist care within 8 weeks.
Oncology (Cancer) Care (High-Volumne)	You should receive routine oncology care within 6 weeks.

Type of Care Needed	How Long You May Wait to Get Care
Mental Health and Substance Use Disorder Treatment 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 follow-up routine care within 30 business days.

If you have a hard time getting care within the standard timeframe, call Member Services. We will help you find another provider. If providers in our network are too far away or cannot give you the care you need, we can help you find an out-of-network provider to give you care.

As a member of our plan:

- You have the right to get all services that Molina Dual Options MyCare Ohio must provide and to choose the provider that gives you care whenever possible and appropriate.
- You have the right to be sure that others cannot hear or find you when you are getting medical care.
- You have the right to access an adequate network of primary and specialty providers. This means our network should have an acceptable amount and quality of doctors. We should have a variety of providers who can meet your physical access, communication, and scheduling needs. These providers should also be monitored for clinical quality and meet reporting requirements.
- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3.
    - Call Member Services or look in the Provider and Pharmacy Directory to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a network women's health specialist for covered women's health services without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care. See the chart above in Section C. The chart tells you the reasonable amount of time you may wait to get care, depending on the type of care you need.

- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get fair advance notice, in writing, of any transfer to another treatment setting and the reason for the transfer.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. A restraint is any method that makes it so you cannot move around freely. Seclusion is being kept alone, without your consent, in an area where you are not allowed to leave freely. Providers cannot use restraint or seclusion as a way to get you to do something, to punish you, or to make their jobs easier.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

- Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have the right to be ensured of confidential handling of information concerning your diagnoses, treatments, prognoses, and medical and social history.
- You have rights related to your information and to control how your PHI is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your PHI.

D1. How we protect your PHI

You have the right to be given information about your health. This information may also be available to someone who you have legally authorized 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.

We make sure that unauthorized people do not find or change your records.

Except for the cases noted below, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.

D2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records if it isn't to transfer the records to a new provider.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

Your 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.

PHI means *protected health information*. PHI includes your name, member number, race, ethnicity, language needs, or other things that identify you. Molina wants you to know how we use or share your PHI.

Why does Molina use or share our Members' 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 use or share PHI for other purposes as required or permitted by law.

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have shared your PHI with

How does Molina protect your PHI?

Molina uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina protects PHI:

- Molina has policies and rules to protect PHI.
- Molina limits who may see PHI. Only Molina staff with a need to know PHI may use it.
- Molina staff is trained on how to protect and secure PHI.
- Molina staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What must Molina do by law?

- Keep your PHI private.
- Give you written information, such as this on our duties and privacy practices about your PHI.
- Follow the terms of our Notice of Privacy Practices.

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way.

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our members' PHI. Our Notice of Privacy Practices is mailed to new members when they join our plan. It is on our website at www.MolinaHealthcare.com/Duals. You may also get a copy of our Notice of Privacy Practices by calling our Member Services Department at (855) 665-4623, Monday - Friday, 8 a.m. to 8 p.m. local time. TTY users, call 711.

E. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of Molina Dual Options MyCare Ohio, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. This is a free service. We can also give you information in large print, braille, or audio. Please contact Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time to request materials in a language other than English or in an alternate format.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including but not limited to:
    - Financial information
    - How the plan has been rated by plan members
    - The number of appeals made by members
    - How to leave the plan
- Our network providers and our network pharmacies, including:
    - How to choose or change primary care providers (PCP). You can change your PCP to another network PCP monthly. We must send you something in writing that says who the new PCP is and the date the change began.
    - Qualifications of our network providers and pharmacies
    - How we pay providers in our network
    - A list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at www.MolinaHealthcare.com/Duals.
    - Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
    - Services and drugs covered by the plan
    - Limits to your coverage and drugs
    - Rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:
    - Put in writing why something is not covered
    - Change a decision we made
    - Pay for a bill you got

F. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7.

G. Your right to get your Medicare and Part D coverage from Original Medicare or another Medicare plan at any time by asking for a change

- You have the right to get your Medicare health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- You must continue to get your Medicaid services from a MyCare Ohio plan.

If you want to make a change, you can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY users should call 7-1-1), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.

H. Your right to make decisions about your health care

H1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices** and be told about all the kinds of treatment provided in a way appropriate to your condition and ability to understand.
- **Know the risks** and be told about any risks involved.
    - You must be told in advance if any service or treatment is part of a research experiment.
    - You have the right to refuse experimental treatments.
- **Get a second opinion** by using another qualified network provider before deciding on treatment.
    - If a qualified network provider is not able to find you, we will arrange a visit with a non-network provider at no cost to you.

- **Say "no"** and refuse any treatment or therapy.
    - This includes the right to:
        - leave a hospital or other medical facility, even if your doctor advises you not to.
        - stop taking a drug.
    - If you say no to treatment, therapy or taking a drug, the doctor or Molina Dual Options MyCare Ohio must talk to you about what could happen and they must put a note in your medical record.
    - If you refuse treatment or stop taking a drug, you will not be dropped from the plan.
    - However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care** and get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles** and refuse treatment from a student.

H2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

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 their 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 their 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 Treatmen**t

  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 Midwest Care Alliance's website at: www.midwestcarealliance.org

- **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

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid may also have advance directive forms. The forms are also currently available on the following website: www.proseniors.org/advance-directives/.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

H3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Ohio Department of Health by calling 1-800-342-0553 or emailing HCComplaints@odh.ohio.gov.

I. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint. We will also send you a notice when you can make an appeal directly to the Bureau of State Hearings within the Ohio Department of Job and Family Services.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

You are free to exercise all of your rights knowing that Molina Dual Options MyCare Ohio, our network providers, Medicare, and the Ohio Department of Medicaid will not hold it against you.

You also have the right to recommend changes to Molina Dual Options MyCare Ohio's rights and responsibilities policy.

If you believe you have been treated unfairly and it is not about discrimination for the reasons listed in Section A2 of this chapter or you would like more information about your rights, you can get help by calling:

- Member Services. You can call Member Services to recommend changes to the rights and responsibilities policy.
- The Ohio Medicaid Consumer Hotline at 1-800-324-8680 (TTY users call 7-1-1), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The MyCare Ohio Ombudsman in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 am to 5:00 pm. Refer to Chapter 2 for more information about this organization.

J. Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care** providers that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements. Review your medications during office visits to keep the list current.
  - Take the prescription drugs prescribed for you by your doctor.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
  - Call your doctor 24 hours in advance if you will be late or if you cannot keep your appointment.
  - Call Molina Healthcare within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.
  - If you are admitted to a hospital, schedule an office visit with your doctor. Schedule the visit within 30 days of leaving the hospital. If you are given a discharge summary when you leave the hospital, bring it to your office visit.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:

  - Medicare Part A and Medicare Part B premiums. For nearly all Molina Dual Options MyCare Ohio members, Medicaid pays the Part A premium and Part B premium. If you pay your Part A and/or part B premium and think Medicaid should have paid, you can contact your County Department of Job and Family Services and ask for assistance.
  - Members who live in nursing homes or other long-term care settings may be responsible for paying a portion of their health care costs.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Molina Dual Options MyCare Ohio. Chapter 1 tells about our service area.
  - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area.
  - Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Medicaid.
  - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you. Refer to Section K in Chapter 1 for more information. You must also notify your County Caseworker at the local County Department of Job and Family Services.
- Call Member Services for help if you have questions or concerns.
  - Tell Molina Healthcare if you would like to change your 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 us if you have any changes that could affect your Medicaid eligibility.
  - Ask questions if you do not understand your benefits.
  - Report any fraud or wrongdoing to Molina Healthcare or the proper authorities.

J1. Estate recovery program

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

You can contact the Medicaid Estate Recovery Unit of the Attorney General's Office by mail or phone at:

Medicaid Estate Recovery Unit
30 E. Broad Street, 14th Floor
Columbus, Ohio 43215
614-779-0105

You can also contact the Ohio Medicaid Hotline at 1-800-324-8680 for more information.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights to ask for a coverage decision, an appeal or make a complaint. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter explains the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services. **You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 to help guide you through your problem.**

For additional resources to address your concerns and ways to contact them, refer to Chapter 2 for more information on ombudsman programs.

Table of Contents

A . What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. About the legal terms

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination," "benefit determination," "at-risk determination," or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. You can contact any of the following resources for help.

Getting help from Molina Dual Options MyCare Ohio's Member Services

Member Services can help you with any problems or complaints about your health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. The call is free.
- Visit our website at www.MolinaHealthcare.com/Duals to send a question, complaint, or appeal.
- Fill out the appeal/complaint form on page 189 of this chapter or call Member Services and ask us to mail you a form.

- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your Molina Dual Options MyCare Ohio Member ID Card, and your address and telephone number. You should also send any information that helps explain your problem.

  Mail the form or your letter to:
  Molina Dual Options MyCare Ohio
  Attn: Grievance and Appeals
  P.O. Box 22816
  Long Beach, CA 90801-9977
  FAX: 562-499-0610

Getting help from the Ohio Department of Medicaid

If you need help, you can always call the Ohio Medicaid Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do about your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. The call is free. You can also visit the Ohio Department of Medicaid website at www.medicaid.ohio.gov.

Getting help from the MyCare Ohio Ombudsman

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman is an ombudsman program that can help you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. Refer to Chapter 2 for more information on ombudsman programs.

The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 711), Monday through Friday from 8:00 am to 5:00 pm. You can also submit an online complaint at: aging.ohio.gov/contact. The services are free.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1 877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

Getting help from other resources

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or other provider that requested the service can submit a Level 1 appeal on your behalf.
    - If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name them as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your "representative."
    - If you want someone to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.MolinaHealthcare.com/Duals. The form gives the person permission to act for you. You must give us a copy of the signed form.
- You can talk to a lawyer. You may call your own lawyer or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Aid toll-free at 1-866-529-6446 (1-866-LAW-OHIO). If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.

C . Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.)	
Yes. My problem is about benefits or coverage. Refer to **Section D: "Coverage decisions and appeals"** on page 150.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 186.

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources listed in Section B1 on page 147.

D2. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- Section E on page 152 gives you information if you have problems getting medical care or items, dental or vision services, behavioral health services, long-term services and supports, and prescription drugs (but not Part D drugs). For example, use this section if:
    - You are not getting medical care you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
        - **NOTE:** Only use Section E for problems with drugs not covered by Part D. Drugs in the List of Covered Drugs, also known as the Drug List, with a (*) are not covered by Part D. Refer to Section F on page 166 for Part D drug appeals.
    - You got medical care or services you think should be covered, but we are not paying for this care.

- You got and paid for medical services or items you thought were covered, and you want to ask us to pay for the services so your payment can be refunded.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
  - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 174 and 180.
- Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- Section F on page 166 gives you information if you have problems about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior authorization (PA) or approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought so your payment can be refunded. (This is asking for a coverage decision about payment.)
- Section G on page 174 gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- Section H on page 180 gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

If you need other help or information, please call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 711).

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical care or items, dental or vision services, behavioral health services, and long-term services and supports. You can also use this section for problems with drugs that are not covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with a (*) are not covered by Part D. Use Section F for Part D drug appeals.

This section tells what you can do if you are in any of the following situations:

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 153 for information on asking for a coverage decision.

2. You want us to cover a benefit that requires plan approval (also called prior authorization (PA)) before you get the service.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 153 for information on asking for a coverage decision.

   NOTE: Refer to the Benefits Chart in Chapter 4 for a general list of covered services as well as information on what services require PA from our plan. Refer to the Drug List to find out if any drugs require PA. You can also find the lists of services and drugs that require PA at www.MolinaHealthcare.com/Duals.

3. We did not approve care your doctor wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 156 for information on making an appeal.

4. We did not approve your request to get waiver services from a specific network non-agency or participant-directed provider.

   What you can do: You can appeal our decision to not approve the request. Refer to section E3 on page 156 for information on making an appeal.

5. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 156 for information on making an appeal.

6. You got and paid for services or items you thought were covered, and you want us to work with the provider to refund your payment.

   What you can do: You can ask us to work with the provider to refund your payment. Refer to page 165 of this section for information on asking for payment.

7. We reduced, suspended, or stopped your coverage for a certain service or item, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce, suspend, or stop the service or item. Refer to Section E3 on page 156 for information on making an appeal.

   NOTE: If we tell you that previously approved services or items will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to get the services and items during the appeal. Read "Will my benefits continue during Level 1 appeals" on page 160.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections G or H on pages 174 and 180 to find out more.

8. We did not make a coverage decision within the timeframes we should have.

   What you can do: You can file a complaint or an appeal. Refer to Section J on page 186 for information on making a complaint. Refer to Section E3 on page 156 for information on making a Level 1 Appeal.

   NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 711).

9. We did not make an appeal decision within the timeframes we should have.

   What you can do: You can file a complaint. Refer to Section J on page 186 for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing. Refer to Section E4 on page 160 for information on asking for a State Hearing. Note that if your problem is about coverage for a Medicare service or item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

   NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 711).

E2. Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (refer to Section F for Medicare Part D drugs)

To ask for a coverage decision, call, write, or fax us, or ask your authorized representative or doctor to ask us for a decision.

- You can call us at: (855) 665-4623 TTY: 711 Monday – Friday, 8 a.m. to 8 p.m., local time
- You can fax us at:
  - Inpatient Fax: (844) 834-2152
    - For Home Health & Hospice Room and Board T2046 Only: (877) 708-2116
  - Outpatient Fax: (844) 251-1451

- You can write to us at: Molina Dual Options MyCare Ohio, Attention: Utilization Management, P.O. Box 349020, Columbus, OH 43234-9020

Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. *We will also accept a letter or other appropriate form to authorize your representative*. For more information, refer to Section B1 on page 147.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid or Medicare Part B prescription drugs within 72 hours after we receive your request.

We will make a standard coverage decision on all other services and items within 10 calendar days after you asked. If we don't give you our decision within 10 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 24 hours for Medicaid or Medicare Part B prescription drugs and within 48 hours for all other services and items.

The legal term for "fast coverage decision" is **"expedited determination."**

Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at: (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time
- You can fax us at:
    - Inpatient Fax: (844) 834-2152

- For Home Health & Hospice Room and Board T2046 Only: (877) 708-2116
- Outpatient Fax: (844) 251-1451

For details on how to contact us, refer to Chapter 2.

- You can also have your doctor or your authorized representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical items and/or services you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for items or services you already got.)
2. You can get a fast coverage decision **only if the standard deadlines could cause serious harm to your health or hurt your ability to function**. The standard deadlines are 72 hours for Medicaid or Medicare Part B prescription drugs and 10 calendar days for all other services and items.

- If your doctor says that you need a fast coverage decision, we will automatically give you one.
- If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
  - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines (72 hours for Medicaid or Medicare Part B prescription drugs) instead to make our decision.
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 186.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or other provider disagree with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. We will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.

NOTE: If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name them as your representative in writing. Read "Can someone else make the appeal for me" on page 157 for more information.

If you need help during the appeals process, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 711). The MyCare Ohio Ombudsman is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

How do I make a Level 1 Appeal?

- To start your appeal, you, your authorized representative, or your doctor or other provider must contact us. You can call us at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or write to us at the following address:

  Molina Dual Options MyCare Ohio

  Attention: Grievance and Appeals

  P.O. Box 22816

  Long Beach, CA 90801-9977.

  Medicare.AppealsandGrievances@MolinaHealthCare.com

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

- If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 189. Be sure to include your first and last name, the number from the front of your Molina Dual Options MyCare Ohio Member ID Card, and your address and telephone number. You should also include any information that helps explain your problem.
- For additional details on how to reach us for appeals, refer to Chapter 2.
- You can ask us for a "standard appeal" or a "fast appeal."

The legal term for "fast coverage decision" is **"expedited determination."**

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at www.MolinaHealthcare.com/Duals. We will also accept a letter or other appropriate form to authorize your representative.

If the appeal comes from someone besides you or your doctor or other provider that requested the service, we must get your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf, we must get your written authorization.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** after the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 appeals" on page 160 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to find out if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 15 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 186.
- If we do not give you an answer to your appeal within 15 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (refer to Section E4 on page 160). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing (refer to Section E4 on page 160).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to Section J on page 186).

If our answer is Yes to part or all of what you asked for, we must approve the service within 15 calendar days after we get your appeal (or within 7 days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (refer to Section E4 on page 160). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to Section E4 on page 160).

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 186.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (refer to Section E4 on page 160). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing (refer to Section E4 on page 160).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to Section J on page 186).

If our answer is Yes to part or all of what you asked for, we must authorize the coverage within 72 hours after we get your appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case

to the Independent Review Entity for a Level 2 Appeal (refer to Section E4 on page 160). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to Section E4 on page 160).

Will my benefits continue during Level 1 appeals?

Yes, if you meet certain requirements. If we previously *approved coverage for a service* but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or *other provider* must **ask for an appeal on or before the later of the following** to continue the service during the appeal:

- Within 15 calendar days of the mailing date of our notice of action; or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; or (2) 15 calendar days pass after we notify you that we said **No** to your appeal.

NOTE: Sometimes your benefits may continue even if we say **No** to your appeal. If the service is covered by Medicaid and you ask for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision. If the service *is* covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process. For more information, refer to Section E4 on page 160.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicaid** service or item, the letter will tell you that you may ask for a State Hearing. Refer to page 161 of this section for information on State Hearings.
- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that could be primarily covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will tell you that you may also ask for a State Hearing. Refer to page 161 of this section for information on State Hearings.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

If we say **No** to your Appeal at Level 1 and the service or item is usually covered by Medicaid, you may ask for a State Hearing.

What is a State Hearing?

A State Hearing is a meeting with you or your authorized representative, our plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think our plan did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.

We will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home & Community-Based Services Waiver Member Handbook for more information about your rights.

How do I ask for a State Hearing?

To ask for a State Hearing, you or your authorized representative must contact the Bureau of State Hearings **within 120 calendar days** of the date that we sent the notice of your State Hearing rights. The 120 calendar days begins on the day after the mailing date on the notice. If you miss the 120 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. Remember, you have to ask for a Level 1 Appeal before you can ask for a State Hearing.

NOTE: If you want someone to act on your behalf, including your doctor or other provider, you must give the Bureau of State Hearings written notice saying that you want that person to be your authorized representative.

- You can sign and send the State Hearing form to the address or fax number listed on the form or submit your request by e-mail to bsh@jfs.ohio.gov. You can also call the Bureau of State Hearings at 1-866-635-3748.

How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the Bureau of State Hearings gets your request. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed, but no later than 3 working days after the Bureau of State Hearings gets your request.

My problem is about a service or item that is covered by Medicare. What will happen at the Level 2 Appeal?

If we say No to your Appeal at Level 1 and the service or item is usually covered by Medicare, you will automatically get a Level 2 Appeal from the Independent Review Entity (IRE). An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

How long does it take to get an IRE decision?

- The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.
    - However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.
    - However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item is covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also ask for a State Hearing. To ask for a State hearing, follow the instructions in this section on page 161.

Will my benefits continue during Level 2 appeals?

If we decide to change or stop coverage for a service that was previously approved, you can ask to continue your benefits during Level 2 Appeals in some cases.

- If your problem is about a service primarily covered by **Medicaid only**, you can ask to continue your benefits during Level 2 appeals. You or your authorized representative must **ask for a State Hearing before the later of the following** to continue the service during the State Hearing:
    - Within 15 calendar days of the mailing date of our letter telling you that we denied your Level 1 appeal; or
    - The intended effective date of the action.
- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the Independent Review Entity (IRE).
- If your problem is about a service primarily covered by **both Medicare and Medicaid**, your benefits for that service will automatically continue during the Level 2 appeal process with the IRE. If you also ask for a State Hearing, you can continue your benefits while the hearing is pending if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; (2) all entities that got your Level 2 Appeal (the IRE and/or Bureau of State Hearings) decide **No** to your request.

How will I find out about the decision?

If your Level 2 Appeal was a State Hearing, the Bureau of State Hearings will send you a written hearing decision in the mail.

- If the hearing decision is **Yes** (sustained) to all or part of what you asked for, the decision will clearly explain what our plan must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services for assistance.
- If the hearing decision is **No** (overruled) to part or all of what you asked for, it means the Bureau of State Hearings agreed with the Level 1 decision. The State Hearing decision will explain the Bureau of State Hearings' reasons for saying No and will tell you that you have the right to request an Administrative Appeal.

If your Level 2 Appeal went to the Independent Review Entity (IRE), the Independent Review Entity (IRE) will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?

If either the Independent Review Entity or the Bureau of State Hearings decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal was a State Hearing, you can appeal again by asking for an Administrative Appeal. The Bureau of State Hearings must get your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to Section I on page 185 for more information on additional levels of appeal.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself**. We will contact the provider directly and take care of the problem. It is possible that we will pay the provider so they can refund your payment, or the provider will agree to stop billing you for the service.

For more information, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask us to assist you with payment you made to a provider or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment. Chapter 7 also gives information to help you avoid payment problems in the future.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will work with the provider to refund your payment.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 156. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking to be paid back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should make payment, we must send the payment to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 185 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicaid, you can request a State Hearing (refer to Section E4 on page 160).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals**.

The Drug List includes some drugs with a *(*)*. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with *(*)* symbol follow the process in Section E on page 152.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment. Remember, you should not have to pay for any medically necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services for assistance.

The legal term for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 167. Also refer to Sections F3 and F4 on pages 168 and 169.	Skip ahead to **Section F4** on page 169.	Skip ahead to **Section F4** on page 169.	Skip ahead to **Section F5** on page 171.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5).
   - The extra rules and restrictions on coverage for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization" (PA).)
     - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - Quantity limits. For some drugs, we limit the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

F3. Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 171 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at (855) 665-4623. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section B on page 147 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you paid for a drug that you think should be covered, read Chapter 7 of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.
- If you are asking for an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

At a glance: How to ask for a coverage decision about a Part D drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- **A standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- **A fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

The legal term for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function**.

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 186.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 ours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said No. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.

If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

If you want a fast appeal, you may make your appeal in writing or you may call us.

Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4 on page 169.

The legal term for "fast appeal" is **"expedited determination."**

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to find out if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."

- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If we approve a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will automatically send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

The legal term for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
    - If the IRE approves a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE with the decision of your Level 2 appeal will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called "An Important Message from Medicare about Your Rights." If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The "Important Message" tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you.

In Ohio, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: (888) 524-9900, TTY: (888) 985-8775.

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. An Important Message from Medicare about Your Rights contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at (888) 524-9900, TTY: (888) 985-8775 and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4 on page 178.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for "fast review" is **"immediate review."**

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: (888) 524-9900, TTY: (888) 985-8775.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at (888) 524-9900, TTY: (888) 985-8775 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

G4. What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your hospital stay. We check to find out if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes to your fast review**, it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
    - It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
    - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said No to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 186 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

H. What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only when they are covered by Medicare:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying the cost for your care.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 186 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. Or call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: (888) 524-9900, TTY: (888) 985-8775. Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at **(888) 524-9900, TTY: (888) 985-8775** and ask a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 184.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: (888) 524-9900, TTY: (888) 985-8775. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at (888) 524-9900, TTY: (888) 985-8775 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to find out if the decision about when your services should end was fair and followed all the rules.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services. To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 186 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

I. Taking your appeal beyond Level 2

I1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting

must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can contact the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MyCare Ohio Ombudsman. The phone number is 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

I2. Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at 1-866-635-3748.

J. How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, receiving a bill, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

You think that someone did not respect your right to privacy, or shared information about you that is confidential.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 189.

If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Molina Dual Options MyCare Ohio staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about receiving a bill

- Your doctor or provider sent you a bill.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term for "complaint" is a **"grievance."**

The legal term for "making a complaint" is **"filing a grievance."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. **If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 711)**.

J2. Internal complaints

To make an internal complaint, call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. Complaints related to Part D must be made **within 60 calendar days** after you had the problem you want to complain about. All other complaints can be made **at any time** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can also use the form on page 189 to submit the complaint.
- Complaints are grievances that must be resolved as quickly as needed, based on your health status. Complaints must be resolved within 30 calendar days of when we receive the grievance. Complaints filed orally may be responded to orally unless you request a written response or the complaint concerns quality of care. Complaints filed in writing must be responded to in writing. You can file a complaint orally by calling us at (855) 665-4623, TTY: 711, Monday– Friday, 8 a.m. to 8 p.m., local time. You can also file a complaint in writing by mailing your complaint to: Molina Dual Options MyCare Ohio, Attention: Appeals and Grievances, PO Box 22816, Long Beach, CA 90801, Fax: (562) 499-0610.

The legal term for "fast complaint" is **"expedited grievance."**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer complaints about access to care within 2 business days. We answer all other complaints within 30 calendar days. If we need more information and the delay is in your

best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.

- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell Medicaid about your complaint

You can call the Ohio Medicaid Hotline at 1-800-324-8680 or TTY 1-800-292-3572. The call is free. You can also e-mail your complaint to bmhc@medicaid.ohio.gov.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr.

You may also contact the local Office for Civil Rights office at:

Office for Civil Rights

United States Department of Health and Human Services

233 N. Michigan Ave., Suite 240

Chicago, Illinois 60601

You may also have rights under the Americans with Disability Act and under any applicable state law. You can contact Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time or the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572) for assistance.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2.

In Ohio, the Quality Improvement Organization is called Livanta. The phone number for Livanta is (888) 524-9900, TTY: (888) 985-8775.

Chapter 10: Changing or ending your membership in our MyCare Ohio Plan

Introduction

This chapter tells about ways you can change or end your membership in our plan. You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services). You can end your membership in our plan by choosing a different MyCare Ohio plan. If you leave our plan, you will still be in the Medicare and Ohio Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.

Table of Contents

A. MyCare Ohio

You can end your membership in Molina Dual Options MyCare Ohio Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

If you change your membership in our plan by choosing to get Medicare services separately:

- You will keep getting Medicare services through our plan until the last day of the month that you make a request.
- Your new Medicare coverage will begin the first day of the next month. For example, if you make a request on January 18th to not have Medicare through our plan, your new Medicare coverage will begin February 1st.

If you end your membership in our plan by choosing a different MyCare Ohio plan:

- If you ask to switch to a different MyCare Ohio plan before the last five days of a month, your membership will end on the last day of that same month. Your new coverage in the different MyCare Ohio plan will begin the first day of the next month. For example, if you make a request on January 18th, your coverage in the new plan will begin February 1st.
- If you ask to switch to a different MyCare Ohio plan on one of the last five days of a month, your membership will end on the last day of the following month. Your new coverage in the different MyCare Ohio plan will begin the first day of the month after that. For example, if we get your request on January 30th, your coverage in the new plan will begin March 1st.

You can get more information about when you can change or end your membership by calling:

- The Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5 for information about drug management programs.

B. How to change or end your membership in our plan

If you decide to change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711; **or**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 194.

Refer to Section A above for information on when your request to change or end your membership will take effect.

C. How to join a different MyCare Ohio plan

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different MyCare Ohio plan

To enroll in a different MyCare Ohio plan:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711.

Your coverage with Molina Dual Options MyCare Ohio will end on the last day of the month that we get your request.

D. How to get Medicare and Medicaid services

If you do not want to enroll in a different MyCare Ohio plan, you will return to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by Molina Dual Options MyCare Ohio.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically stop getting Medicare services from our plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan, which would include Medicare prescription drug coverage**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711. You will automatically stop getting Medicare services through Molina Dual Options MyCare Ohio when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can select a Part D plan at this time. If you need help or more information: • Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711. You will automatically stop getting Medicare services through Molina Dual Options MyCare Ohio when your Original Medicare and prescription drug plan coverage begins.

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call your Ohio Senior Health Insurance Information Program (OSHIIP) at (800) 686-1578, Monday – Friday, 7:30 a.m. to 5 p.m. local time.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711. You will automatically stop getting Medicare services through Molina Dual Options MyCare Ohio when your Original Medicare coverage begins.

D2. How to get your Medicaid services

You must get your Medicaid benefits from a MyCare Ohio plan. Therefore, even if you do not want to get your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from Molina Dual Options MyCare Ohio or another MyCare Ohio managed care plan.

If you do not enroll in a different MyCare Ohio plan, you will remain in our plan to get your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care.

Once you stop getting Medicare services through our plan, you will get a new Member ID Card and a new Member Handbook for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to get your Medicaid benefits, call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711.

E. Keep getting your medical items, services and drugs through our plan until your membership ends

If you change or end your enrollment with Molina Dual Options MyCare Ohio, it will take time before your new coverage begins. During this time, keep getting your Medicare and Medicaid services through our plan.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Molina Dual Options MyCare Ohio changes or ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

These are the cases when Medicare and Medicaid must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage. Medicare services will end on the last day of the month that your Medicare Part A or Medicare Part B ends.
- If you no longer qualify for Medicaid or no longer meet MyCare Ohio eligibility requirements. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months or you establish primary residence outside of Ohio.
- If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can ask Medicare and Medicaid to end your enrollment with our plan for the following reasons:

- If you intentionally give incorrect information when you are enrolling and that information affects your eligibility.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members.
- If you let someone else use your Member ID Card to get medical care.
    - your membership ends for this reason, Medicare and/or Medicaid may have your case investigated by the Inspector General. Criminal and/or civil prosecution is also possible.

G. Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

You should also call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 711.

H. Your right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan

If we ask Medicare and Medicaid to end your membership in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance or make a complaint about our request to end your membership. You can also refer to Chapter 9 for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when Medicare and Medicaid can end your membership, you can call Member Services at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

Chapter 11: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: The things you do on a normal day. These things include eating, using the toilet, getting dressed, bathing, brushing your teeth, and other daily actions.

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

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

Annual Notice of Changes: A list of benefits, covered services and rules that changed from the year before.

Appeal: A request for a formal review of an adverse benefit determination (the review of a denial of payment or prior authorization for an item or service).

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

Billing: See "Improper/Inappropriate Billing."

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar: A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand Name Drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. See "Generic Drug."

Care Manager: A person who works with you, the health plan and your health care providers to make sure you get the care you need. This person is on your Care Team. They work with you and the team to make your Care Plan.

Care Plan: A plan for what services you will get and how you will get them. You will have a choice in making your Care Plan. Your plan may include goals for your physical and mental health. Your plan may include services for:

- Medical needs
- Behavioral health
- Long-term services and supports

Care Team: A care team may include doctors, nurses, social workers, counselors or other caregivers. Your care team is there to help you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal government agency in charge of Medicare. Chapter 2 explains how to contact CMS.

Certified Application Counselor: A person who is trained to help consumers look for health care coverage options and fill out application forms.

Complaint: A complaint can also be called a "grievance." A grievance is when you tell us that you are unhappy with us or with any of our employees, vendors, or contracted providers. You can call or write to us if you have a grievance. Examples of grievances include complaints about the quality of care you received, rudeness, or any failure to respect your rights as a member.

Comprehensive Outpatient Rehabilitation Facility (CORF): A place where you get services after an illness, accident, or major operation. It gives many services, including:

- Physical therapy
- Social or psychological services
- Respiratory therapy
- Occupational therapy
- Speech therapy
- Home environment evaluation services

Community Connector: A Molina Dual Options MyCare Ohio staff member who lives in your area. They will make home visits and give your feedback to your Care Team. This helps address concerns before they get more serious. Because they live in your community, Community Connectors can connect you with local social services like food, housing, and work.

County Caseworker: Your contact at your local County Department of Job and Family Services (CDJFS) office. Contact this person if you have questions about your Medicaid benefits.

Contact this person to make sure your Medicaid benefits are renewed every 12 months. Also, tell this person when information about you changes, like when you have a baby or move to a new address.

County Department of Job and Family Services (CDJFS): Your local CDJFS office decides if you are eligible for Medicaid and other government-sponsored programs, like the Food Assistance Program. Find your local office at http://www.jfs.ohio.gov/county/county_directory.pdf.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services that require prior authorization (see "Prior Authorization"). It also includes the amount we will pay for your services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The prescription drugs covered by our plan.

Covered services: The services and supplies covered and paid for by our plan.

Disenrollment: The process of ending your membership in our plan. It may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three (3) tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, diabetic supplies, IV infusion pumps, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: An emergency is when you have a medical problem that is so serious it must be treated right away by a doctor. Emergency services may be needed to stop death, loss of a body part or loss of function.

Emergency care: Covered services needed to treat an emergency.

Enrollment: The process of beginning your membership in our plan. It may be voluntary (your own choice) or passive (membership was assigned).

Exception: Permission to get coverage for a prescription drug that is not normally covered, or to use the drug without certain rules and limitations.

Explanation of Benefits (EOB): A report to help you understand and keep track of your payments for your Part D prescription drugs. This report tells you the total amount we or others on your behalf have paid for your prescription drugs during the month. Call Member Services to ask for your Explanation of Benefits.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy" or "LIS."

Formulary: See "List of Covered Drugs (Drug List)."

Fraud, Waste and Abuse:

- **Fraud:** An unfair or unlawful act 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: See "Complaint."

Health plan: An organization that contracts with providers for the services you get. Molina Dual Options MyCare Ohio is your health plan.

Health assessment: A review of your medical history, medications, and current condition. It is used to determine your health status and how it may change in the future.

Home and community-based services: See "Long-term services and supports (LTSS)."

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist. For example, a person who helps with personal care (see "Activities of Daily Living").

Hospice: A program to help people who have a terminal diagnosis. This means that the person has a life-ending illness. The person is expected to have six months or less to live. A person with a terminal diagnosis has a right to this care. The program helps the person live comfortably. A trained team of caregivers meets all the person's needs. This includes physical, emotional, social, and spiritual care. Our plan must give you a list of hospice providers in your area.

Improper/Inappropriate Billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Molina Dual Options MyCare Ohio Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

Because Molina Dual Options MyCare Ohio pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for cost-sharing amounts.

Inpatient: A word used when you enter a hospital or skilled nursing facility. You must be formally admitted. If you were not, you might still be considered an outpatient, even if you stay overnight.

List of Covered Drugs (Drug List): 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."

Long-Term Services and Supports (LTSS): Medical, personal, and social services that help a person with a long-term condition. Most of these services are to help you stay in your home. This is done so you do not have to go to a nursing home for a long period of time. LTSS in Ohio are Home and Community-Based Services (HCBS) and some facility-based services. They help you live in the least limiting setting possible.

Low-Income Subsidy (LIS): See "Extra Help."

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

Medicaid Renewal: The process of confirming your Medicaid eligibility to continue receiving Medicaid benefits. You must complete your Medicaid renewal every 12 months or you may lose your Medicaid coverage. See Chapter 2 to learn more about how to renew your Medicaid coverage.

Medically Necessary: The services needed to prevent, diagnose, or treat your medical condition or stay at your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are needed under Medicare or Medicaid coverage rules.

Medicare: The federal health insurance program for people age 65 or older and some people under age 65 with certain disabilities. It is also for people with end-stage renal disease. This means those with permanent kidney failure who need dialysis or a kidney transplant. People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare Advantage Plan: A Medicare program, also known as "Medicare Part C" or "MA Plans," that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-Covered Services: Services covered by Medicare Part A and Part B.

Medicare-Medicaid Enrollee (Dual Eligible): A person who qualifies for Medicare and Medicaid.

Medicare Part A: Also called "Part A" for short. This Medicare program covers medically needed services from:

- Hospitals
- Skilled nursing facilities
- Nursing home care, as long as custodial care is not the only care you need

- Home health
- Hospice care

Medicare Part B: Also called "Part B" for short. This Medicare program covers services and supplies that are needed to treat a disease or condition. This includes:

- Lab tests
- Surgeries
- Doctor visits
- Preventive screenings
- Durable medical equipment like wheelchairs and walkers
- Ambulance services
- Behavioral health visits
- Second opinions
- Limited outpatient prescription drugs

Medicare Part C: Also called "Part C" for short. This Medicare program lets private health insurance companies provide Medicare benefits. The companies do this through a Medicare Advantage Plan.

Medicare Part D: Also called "Part D" for short. This is the Medicare prescription drug benefit program. Part D covers:

- Outpatient prescription drugs
- Vaccines
- Some supplies not covered by Part A, Part B or Medicaid

Medicare Part D drugs: Drugs covered under Medicare Part D. The government removed some drugs from Part D. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Ohio Medicaid who qualifies for MyCare Ohio program covered services and has enrolled in our plan. Enrollment in our plan must be confirmed by CMS and the Ohio Department of Medicaid (ODM).

Member Handbook: This document explains your coverage. It says what we must do for you. It also says what you must do as a member of our plan.

Member Services: A department in our plan. Member Services answers questions about your plan, benefits, and concerns. See Chapter 2 to learn how to contact Member Services.

Model of care: A term for the way we take care of our members. It makes sure our members get the right care, in the right setting, and at the right time.

MyCare Ohio: A program that provides both your Medicare and Medicaid benefits together in one health plan. You have one ID card for all your benefits.

Network Pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. They must be licensed or certified by Medicare and Medicaid. They will not charge our members an extra amount. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider: "Provider" is the general term for doctors, nurses, and other health professionals who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and Medicaid to provide health care services. We call them "network providers" when they agree to work with us. They accept our payment in full and do not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing Home or Facility: A place that provides care for people who need more care than can be given at home. It is not for people who need to be in the hospital.

Ohio Department of Medicaid (ODM): The state of Ohio government agency in charge of Medicaid. Chapter 2 explains how to contact ODM.

Ohio Medicaid Hotline: Consumers can call this number to ask questions about how to apply for Medicaid, what is covered by Medicaid and to enroll in a health plan. Call (800) 324-8680 from 7 a.m. to 8 p.m. Monday – Friday or 8 a.m. to 5 p.m. Saturday.

Ombudsman: The MyCare Ohio Ombudsman is an independent advocate that can help with concerns about any aspect of care available through MyCare Ohio. This service is free. See Chapter 2 for the Ombudsman phone number and other contact information.

Organization Determination: When we or one of our providers make a decision. The decision is about whether services are covered, how much we will pay, or how much you have to pay. These are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.

- If you do not want to be in our plan, you can choose Original Medicare.
- Covered drugs that need our plan's prior authorization (PA) are marked in the *List of Covered Drugs*.

Out-of-Pocket Costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement.

Outpatient Surgical Center: A facility that provides simple surgery to people who do not need extended hospital care or stays. Patients served there are not expected to need more than 24 hours of care.

Over-the-counter (OTC) Drugs: Any drug or medicine that a person can buy without a prescription from a health care professional.

Personal health information (also called Protected health Information PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to Molina Dual Options MyCare Ohio's Notice of Privacy Practices for more information about how Molina Dual Options MyCare Ohio protects, uses, and discloses your PHI, as well as your rights with respect to your PHI. Chapter 8 includes a summary of the Notice of Privacy Practices. The full Notice of Privacy Practices is sent to you with your new member materials and is online at www.MolinaHealthcare.com/Duals.

Primary Care Provider (PCP): The doctor or other provider you see first for most health problems and checkups. Your PCP makes sure you get the care you need to stay healthy. Your PCP may refer you to other doctors. Your PCP may also talk with other doctors and providers about your care. See Chapter 3 to learn more about getting care from PCPs.

Prior Authorization: Also called "prior approval." This is approval from our plan. It is needed before you can get certain services or prescription drugs. When our plan makes changes to the list of services that need prior authorization, we will post an update online at www.MolinaHealthcare.com/Duals.

Program for All-Inclusive Care for the Elderly (PACE) Plans: A program that covers Medicare and Medicaid benefits together for people age 55 and older who need some help to live at home. In Ohio, a person must live in certain regions to be eligible.

Prosthetics and Orthotics: Medical devices ordered by your provider. Covered items include:

- Arm, back and neck braces
- Artificial limbs
- Artificial eyes
- Devices needed to replace an internal body part or function. This includes ostomy supplies and enteral and parenteral nutrition therapy.

Provider: The word we use for doctors, nurses and other people who give services and care. It also includes hospitals, home health agencies, clinics and other places that give health services, medical equipment, and long-term services and supports.

Provider and Pharmacy Directory: A list of doctors, facilities, or other providers that you may see as a Molina Dual Options MyCare Ohio member. The list includes pharmacies that you can use to get your prescription drugs. Chapter 1 has more information about the *Provider and Pharmacy Directory*, including how to view the list or get a printed copy of it.

Quality Improvement Organization (QIO): A group of doctors and other health care experts. The group helps improve the quality of care for people with Medicare. They are paid by the government. They must check and improve the care given to members. See Chapter 2 to learn more about how to contact the QIO for Ohio.

Quantity Limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug we cover in each prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Rehabilitation Services: Treatment(s) to help you recover from an illness, accident, or major operation. See Chapter 4 to learn more about these services.

Service Area: The area where a member lives and the health plan provides covered services using network providers.

Skilled nursing facility (SNF): A facility with the staff and equipment to give skilled care. It also may provide skilled rehabilitative services and other related services.

Skilled nursing facility (SNF) care: SNF care and rehabilitation services provided on a continual, daily basis. This includes physical therapy or intravenous (IV) injections that a registered nurse or doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Step Therapy: A coverage rule. It means you must first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security. It is paid to people with limited incomes and resources who have a disability, are blind, or are age 65 and older. SSI benefits are not the same as Social Security benefits.

Telehealth (virtual care): Care you get online, by mobile app, or over the phone. Members can see medical and behavioral health providers with telehealth for many illnesses and injuries. See Chapter 4 to learn more about telehealth.

Urgent Care: Care you get for health problems that cannot wait until your next Primary Care Provider (PCP) visit. This care is for health problems that are not a threat to your life. Most urgent care centers can see you for walk-in visits. Many urgent care centers are open evenings and weekends.

Waiver Service Coordinator: If you are eligible for Waiver Services, you will have a Waiver Service Coordinator. This person will help create a Waiver Service Plan that identifies all your service needs. Then, they will make sure that plan is followed.

Molina Dual Options MyCare Ohio Member Services

CALL	(855) 665-4623 Calls to this number are free. Monday – Friday, 8 a.m. to 8 p.m., local time There are other options after our normal hours. These include self-service and voicemail. Use these options on weekends and holidays. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday – Friday, 8 a.m. to 8 p.m., local time
FAX	(888) 295-4761
WRITE	Molina Dual Options MyCare Ohio PO Box 349020 Columbus, OH 43234-9020
WEBSITE	www.MolinaHealthcare.com

MOLINA HEALTHCARE

MyCareOhio
Connecting Medicare + Medicaid

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter, just call us at (855) 665-4623, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time. Someone who speaks English can help you. This is a free service.

SPANISH

Contamos con servicios de intérprete gratuitos para responder cualquier pregunta que pueda tener acerca de nuestro plan de salud o medicamentos. Para obtener ayuda de un intérprete, llámenos al (855) 665-4623, TTY: 711, de lunes a viernes, de 8 a. m. a 8 p. m., hora local. Una persona que hable español podrá ayudarle. Este es un servicio gratuito.

TRADITIONAL CHINESE

我們有免費的口譯員服務，可回答您對於我們健康或藥物計劃的任何問題。若需要口譯員，請撥打 (855) 665-4623 聯絡，TTY: 711，服務時間爲當地時間的週一到週五的上午 8 點至晚上 8 點。能說中文的人士會爲您提供協助。這是免費的服務。

SIMPLIFIED CHINESE

如果您对我们的健康计划或药品计划有任何疑问，我们可以提供免费的口译服务解答您的疑问。若要获得口译服务，请致电我们，电话：(855) 665-4623，TTY: 711，周一至周五提供服务，服务时间为当地时间上午 8 点至晚上 8 点。说中文的人士会帮助您。这是免费服务。

TAGALOG

Mayroon kaming libreng serbisyo ng tagapagsalin para sagutin ang anumang katanungan na maaaring mayroon ka tungkol sa aming health o drug plan. Para makakuha ng tagpagsalin, tawagan lang kami sa numerong (855) 665-4623, TTY: 711, Lunes – Biyernes, 8 a.m. hanggang 8 p.m. lokal na oras. Makatutulong sa iyo ang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

FRENCH

Nous assurons gracieusement des services d'interprétariat afin de répondre à tout question que vous pourriez avoir sur votre santé ou plan de traitement. Pour obtenir l'assistance d'un interprète, il suffit de nous appeler au (855) 665-4623, TTY : 711, du lundi au vendredi de 8 h à 20 h (heure locale). Une personne parlant français pourra vous assister. Ce service est proposé sans frais.

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VIETNAMESE

Chúng tôi có các dịch vụ phiên dịch miễn phí để trả lời bất kỳ câu hỏi nào của quý vị về chương trình chăm sóc sức khỏe hoặc chương trình thuốc của chúng tôi. Để có phiên dịch viên, chỉ cần gọi cho chúng tôi theo số (855) 665-4623, TTY: 711, Thứ Hai – Thứ Sáu, 8 giờ sáng đến 8 giờ tối, giờ địa phương. Ai đó nói tiếng Việt có thể trợ giúp bạn. Đây là dịch vụ miễn phí.

GERMAN

Wir bieten Ihnen kostenlose Dolmetscherdienste, um Ihre Fragen, die Sie möglicherweise zu unseren Gesundheits- oder Arzneimittelleistungen haben, zu beantworten. Wenn Sie mit einem Dolmetscher sprechen möchten, rufen Sie uns einfach an unter (855) 665-4623, TTY: 711, Montag – Freitag, 8:00 Uhr bis 20:00 Uhr (Ortszeit). Jemand, der Deutsch spricht, hilft Ihnen gerne weiter. Dies ist ein kostenloser Dienst.

KOREAN

당사는 무료 통역 서비스를 통해 건강 또는 처방약 플랜에 대한 귀하의 질문에 답변해 드립니다. 통역 서비스를 이용하시려면 (855) 665-4623, TTY: 711번으로 월요일~금요일 오전 8시~오후 8시(현지 시간)에 문의하시기 바랍니다. 한국어 통역사가 도움을 드릴 수 있습니다. 무료 서비스입니다.

RUSSIAN

Если у вас возникли какие-либо вопросы о вашем плане медицинского обслуживания или плане покрытия лекарственных препаратов, для вас предусмотрены бесплатные услуги переводчика. Чтобы воспользоваться услугами переводчика, просто позвоните нам по номеру (855) 665-4623, телетайп: 711 с понедельника по пятницу с 8:00 до 20:00 по местному времени. Вам поможет специалист, говорящий на русском языке. Эта услуга предоставляется бесплатно.

ARABIC

نوفر خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة قد تراودك حول الخطة الصحية أو خطة الأدوية لدينا. للحصول على مترجم فوري، كل ما عليك هو الاتصال بنا على الرقم 665-4623 (855)، وبالنسبة إلى مستخدمي أجهزة الهواتف النصية (TTY)، يرجى الاتصال على: 711، من الاثنين إلى الجمعة، من الساعة 8 صباحًا حتى الساعة 8 مساءً، بالتوقيت المحلي. ويمكن لشخص يتحدّث اللغة العربية مساعدتك. تقدم هذه الخدمة مجانًا.

ITALIAN

Offriamo un servizio di interpretariato gratuito per rispondere a qualsiasi domanda sul nostro piano sanitario o farmaceutico. Per ottenere un interprete, basta chiamarci al numero (855) 665-4623, TTY: 711, dal lunedì al venerdì, dalle 8.00 alle 20.00 ora locale. Una persona che parla italiano potrà aiutarti. Si tratta di un servizio gratuito.

PORTUGUESE

Dispomos de serviços de interpretação gratuitos para responder a possíveis dúvidas que possa ter sobre o nosso plano de saúde ou plano para medicamentos. Para falar com um intérprete, ligue (855) 665-4623, TTY: 711, segunda – sexta, 8 a.m. até 8 p.m. horário local. Alguém que fala português pode ajudá-lo. Este é um serviço gratuito.

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FRENCH CREOLE

Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan (855) 665-4623, TTY: 711, Lendi – Vandredi, 8 a.m. rive 8 p.m. lè lokal. Yon moun ki pale kreyòl ayisyen ka ede w. Sa a se yon sèvis gratis.

POLISH

Oferujemy bezpłatne usługi tłumacza, który pomoże uzyskać odpowiedzi na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub dawkowania leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić do nas pod numer (855) 665-4623, TTY: 711. Jest on dostępny od poniedziałku do piątku w godzinach od 8:00 do 20:00 czasu lokalnego. Pomocy udzieli osoba mówiąca po polski. Ta usługa jest bezpłatna.

HINDI

हम आपके स्वास्थ्य या ड्रग प्लान से जुड़े किसी भी प्रश्न के लिए आपकी सहायता करने के लिए निःशुल्क दुभाषिया सेवाएं प्रदान करते हैं। दुभाषिया को प्राप्त करने के लिए, बस हमें (855) 665-4623, TTY: 711, सोमवार से शुक्रवार, सुबह 8 बजे से रात 8 बजे स्थानीय समय पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता/सकती है। यह एक निःशुल्क सेवा है।

JAPANESE

弊社の医療保険プランや処方薬プランについてお問い合わせいただく際に無料の通訳サービスをご利用いただけます。通訳をご希望の場合は、（855）665-4623（TTY：711）までお電話にてご連絡ください（営業時間：月～金、午前8時～午後8時）。日本語を話せるスタッフがお手伝いいたします。このサービスは無料でご利用いただけます。

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