# Your Member Handbook

**Iowa**
Medicaid
Last updated 08/2024

**MolinaHealthcare.com/IA**

Iowa Health Link
Iowa HHS

Hawki
Iowa HHS

MOLINA® HEALTHCARE

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# Nondiscrimination Language

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

**Communicating with you is important to us.** To help you talk with us, Molina provides the following services free of charge:

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

**If you need these services, contact Molina at our toll-free number (844) 236-0894 (TTY: 711).**

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person by mail, or email. You can file a grievance with:

Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: **(866) 606-3889 TTY/TDD: 711**
Online: **MolinaHealthcare.AlertLine.com**
Email: **civil.rights@MolinaHealthcare.com**

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

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Phone: **(800) 368-1019, (800) 537-7697 (TDD)**
Complaint forms are available at **hhs.gov/ocr/index.html**

# Language Assistance

**Molina Healthcare of Iowa Member Services: (844) 236-0894 (TTY: 711).**

English: Language assistance services, auxiliary aids and services, larger font, oral translation, and other alternative formats are available to you at no cost. To obtain this, please call the number above.

English (Large Font): Language assistance services, auxiliary aids and services, larger font, oral translation, and other alternative formats are available to you at no cost. To obtain this, please call the number above.

Español (Spanish): Servicios de asistencia de idiomas, ayudas y servicios auxiliares, traducción oral y escrita en letra más grande y otros formatos alternativos están disponibles para usted sin ningún costo. Para obtener esto, llame al número de arriba.

Español (Letra Grande): Servicios de asistencia de idiomas, ayudas y servicios auxiliares, traducción oral y escrita en letra más grande y otros formatos alternativos están disponibles para usted sin ningún costo. Para obtener esto, llame al número de arriba.

中文 (Chinese): 可以免费为您提供语言协助服务、辅助用具和服 务、较大的字体、口译以及其他格式。如有需要请拨打上述电话 号码。

**Tiếng Việt (Vietnamese): Các dịch vụ trợ giúp về ngôn ngữ, các trợ cụ và dịch vụ phụ thuộc, phông chữ khổ lớn, thông dịch bằng lời nói, và các dạng thức thay thế khác hiện có cho quý vị miễn phí. Để có được những dịch vụ này, xin gọi số điện thoại nêu trên.**

Srpsko-Hrvatski (Serbo-Croatian): Nna raspolaganju su vam besplatne jezičke podrške, dodatna pomoć i usluge, krupniji font, usmeni prevod kao i drugi alternativni formati. Da biste sve ovo dobili, molimo vas da nas nazovete na gornji broj.

Deutsch (German): Sprachunterstützung, Hilfen und Dienste für Hörbehinderte und Gehörlose, eine größere Schriftart, eine mündliche Übersetzung sowie weitere alternative Formate werden Ihnen kostenlos zur Verfügung gestellt. Um eines dieser Serviceangebote zu nutzen, wählen Sie die o. a. Rufnummer.

(Arabic): تتوفر خدمات المساعدة اللغوية، والأدوات والخدمات المساعدة، والطباعة بأحرف كبيرة، والترجمة الفورية الشفهية، وغيرها من التنسيقات البديلة من أجلك دون أي تكلف. للحصول على هذه الخدمات، يُرجى الاتصال على الرقم المذكور أعلاه.

ลาว (Lao): ບໍລິການໃຫ້ຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍລິການ ແລະ ຄວາມຊ່ວຍເຫຼືອຕ່າງໆ, ແລະ ຮູບແບບທາງເລືອກອື່ນໆ ມີໃຫ້ເຈົ້າ ຟຣີ. ຫາກຕ້ອງການຮັບຂໍ້ມູນ ກະລຸນາໂທໄປທີ່ໝາຍເລກຂ້າງເທິງ.

한국어 (Korean): 언어 지원 서비스, 보조 지원 및 서비스, 대형 활자본, 통역, 기타 대체 형식을 무료로 이용하실 수 있습니다. 이를 위해 위의 전화번호로 연락해 십시오.

हिंदी (Hindi): आप या जसिकी आप मदद कर रहे हैं उनके के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए

Français (French): Des services gratuits d'assistance linguistique, ainsi que des services d'assistance complémentaires, des polices de caractères plus grosses, de la traduction orale et d'autres formats sont à votre disposition. Pour y accéder, appelez le numéro ci-dessus.

Pennsylvanian Deitsh (Pennsylvanian Dutch): Du kansht hilf greeya mitt dee shprohch, adda annah hilf un services in diffahndi vayya un es kosht dich nix. Fa hilf greeya adda may ausfinna, kawl da phone number do ovvah droh.

ไทย (Thai): บริการความช่วยเหลือด้านภาษา อุปกรณ์และบริการเสริม แบบ อักษรขนาดใหญ่ขึ้น การแปลด้วยปากเปล่า รวมทั้งรูปแบบทางเลือกอื่น ๆ มีให้ คุณใช้ได้โดยไม่เสียค่าใช้จ่าย หากต้องการใช้บริการนี้ กรุณาโทรศัพท์ติดต่อ ที่หมายเลขข้างต้น

Tagalog (Tagalog): May available na libreng mga serbisyo sa tulong sa wika, auxiliary na tulong at serbisyo, mas malaking font, pasalitang pagsasalin, at iba pang alternatibong format para sa iyo. Para kunin ito, pakitawagan ang numero sa itaas.

ကညီ (Karen): ကိုဉ်အတၢ်ဆီဉ်ထွဲမၤစၢၤတၢ်မၤ (Language assistance services), တၢ်မၤစၢၤဝဲဒဉ်တၢ်လၢအကဲထီဉ်တၢ် မၤစၢၤသ့တဖဉ်, လံာ်မံာ်ဖျၢဉ်အဒိဉ်, တၢ်ကတိၤကျိုးထံ, ဒီးတၢ်အက့ၢ်ဂီၤဒိလၢတၢ်ဃုထၢမၤအီၤသ့တဖဉ်အိဉ်ဝဲလၢနဂီၤလၢတလာ်အပှၤက လံၤဘဉ်နှဉ်လီၤ. လၢကဒိးနှၢ်ဘဉ်တၢ်သ့ဉ်တဖဉ်အံၤအဂီၤ, ဝံသးစူၤကီးဘဉ်လီတဲစိနှိဉ်ဂံၢ်ဒ်အဖျါလၢထးအသိးတက့ၢ်.

Русский язык (Russian): Услуги по переводу, вспомогательные средства и услуги, материалы, напечатанные более крупным шрифтом, услуги устного перевода, а также материалы в других, альтернативных, форматах предоставляются Вам совершенно бесплатно. Чтобы получить их, позвоните по указанному выше номеру телефона

For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, call 711 or **(800) 735-2942**, Relay Iowa.

Llame al 711 o **(800) 735-2942**, a Relay Iowa TTY (teléfono de texto para personas con problemas de audición, del habla y ceguera) si necesita asistencia telefónicamente.

# Table of Contents

# Welcome

**Thank you for choosing Molina Healthcare of Iowa!** Ever since our founder, Dr. C. David Molina, opened his first clinic in 1980, it has been our mission to provide quality health care to everyone. We are here for you. And today, as always, we treat our members like family.

**Our job is to make sure you get the care and services you need.** We will communicate with members via phone, mail, email and or text. Call our Member Services at **(844) 236-0894** to get any of these services at no cost to you. This member handbook helps you understand how to get healthcare for you or your family when you need it. It also explains your benefits and your rights and responsibilities as a member of Molina Healthcare of Iowa. Please read this booklet carefully. Molina Healthcare does not deny services based on moral or religious objections.

Molina Healthcare works with other companies to provide services, for example, transportation. Any services provided by any company working with Molina will be held to Molina's standards and will be seamless for you. Should you experience any problems, please contact Member Services.

Would you like a printed handbook? Call Member Services. We will send it to you at no cost. If you would like this handbook in another language or format including braille or large print call Member Services.

# Important Contact Information

### Molina Healthcare of Iowa Member Services

Phone: Toll-Free: **(844) 236-0894 (TTY: 711)**.

Call this number for all Member Services needs, such as:

- Nurses (available 24/7)
- Vision
- Non-Emergency Medical Transportation (NEMT)
- Medical Management
- Health Education
- Care Management
- Physical and Behavioral Health
- Waiver and Facility-Based Services
- Ombudsmen

Hours of Operation: Monday through Friday, 7:30 a.m. to 6:00 p.m. CST.
Website: **MolinaHealthcare.com/IA**
Address: 500 SW 7th Street, Suite 304, Des Moines, Iowa 50309

### On Call Nurse 24/7 (Nurse Advice Line)

**(844) 236-2096**

### Non-Emergency Medical Transportation (NEMT): Access2Care

**(866) 849-2062**

### Vision: March Vision Care

For vision services call **(844) 496-2724**
Hours: Monday to Friday, 8 a.m. to 5 p.m.
Find a vision provider here: **marchvisioncare.com/find.aspx**

## State Contact Information:

### Iowa Medicaid Member Services or Enrollment Broker

**(800) 338-8366**

Call this number for MCO choice counseling and enrollment for IA Health Link members. Iowa Medicaid Member Services can also help with premium payments and financial hardship requests for Iowa Health and Wellness Plan members.
Hours: Monday to Friday, 8 a.m. to 5 p.m.
You can also email Iowa Medicaid Member Services at **IMEMemberServices@hhs.state.ia.us**.

### Hawki Customer Services

**(800) 257-8563**

Call this number for MCO choice counseling and enrollment for Hawki members. Hawki Customer Service can also help with premium payments and questions.
Hours: Monday to Friday, 8 a.m. to 5 p.m.

### Iowa Department of Health and Human Services (HHS) Contact Center

**(855) 889-7985**

Call this number if you are new to Medicaid and have application questions.
Hours: Monday to Friday, 7 a.m. to 6 p.m.

### Iowa Department of Health and Human Services (HHS) Income Maintenance Customer Service Center

**(877) 347-5678**

Call this number to report changes for continued Medicaid eligibility, such as when employment starts and ends.
Find your local HHS office: **HHS.iowa.gov/hhs_office_locator**
Hours: Monday to Friday, 7 a.m. to 6 p.m.

### Child and Dependent Adult Abuse

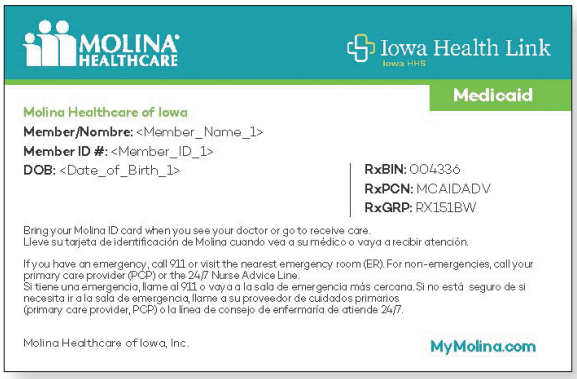
If you suspect that a child is being abused, Iowa law requires you to report this.
Call the Abuse Hotline at **(800) 362-2178**.

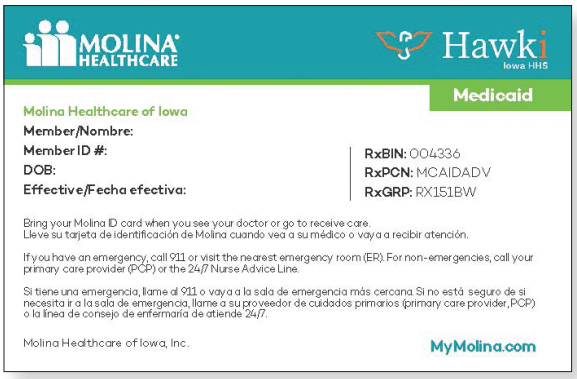
If you suspect abuse or neglect of an adult in the community, call the Abuse Hotline at **(800) 362-2178**. Phone lines are staffed 24 hours a day, 7 days a week. In an emergency, call your local police force or call 911.

## Your ID Cards

### Your member ID card

When you enroll, Molina will mail you a member ID card. You will also get an Iowa Medicaid card. It is important you always carry both ID cards with you. You will need to show them each time you get medical care or fill prescriptions at a pharmacy.



**Show your ID card every time you need care. This includes:**


**Medical Appointments**


**Hospital stays**


**Vision Appointments**


**Emergency room visits**


**Urgent care centers**


**Behavioral Health appointments**


**Getting medical tests**


**Prescriptions and medical supplies**

Always carry both your cards with you and do not let anyone else use them. If you lose your Medicaid card, call Iowa Medicaid Member Services toll-free at **(800) 338-8366**. If you lose your Molina member ID card or did not receive one, we can replace the card. You can also view your ID card on the Molina mobile app until your new card is received. To replace the card, please visit our Secure Member Portal to ask for a new one or call Member Services. The toll-free phone number is **(844) 236-0894 (TTY: 711)**. Anytime you receive a new member ID card from us, please destroy your old one.

# Accessibility

## Accessibility to Information

Molina wants to make sure you understand your benefits. If you have trouble reading what we send you or communicating with us, we can help.

For members who do not speak English, we offer help in many different languages. Call Member Services at **(844) 236-0894** to get any of these services at no cost to you:

- Over-the-phone interpreter services
- Interpretation at your doctor visits, within 24 hours' notice
- This member handbook or any other written materials in your preferred language

If you would like this handbook in another format, including braille or large print, call Member Services at **(844) 236-0894**. We can mail it to you free of charge.

### For members who are deaf or hard of hearing:

- To call us using a TTY relay service, call 711
- We will set up and pay for you to have a person who knows sign language help you during your doctor visits, with 24 hours' notice

### Accessibility to Services

We are committed to ensuring that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment with a provider, or accessing services because of a disability, contact Member Services at **(844) 236-0894 (TTY: 711)** for assistance.

# Eligibility

## What Happens if I Move?

If you move, please contact the Iowa Department of Health and Human Services (HHS) Income Maintenance Customer Call Center at **(877) 347-5678** and contact Molina. Hawki members should contact Hawki Member Services at **(800) 257-8563** and Molina at **(844) 236-0894 (TTY: 711)**.

## If You are No Longer Eligible for Medicaid or Hawki

Molina is here to help with any concerns with eligibility for Medicaid or Hawki. For any questions, please call Member Services at **(844) 236-0894 (TTY: 711)**.

## Renewals

Coverage for most Medicaid programs must be renewed every 12 months. When your renewal date is coming up, Iowa Department of Health and Human Services will send you a letter letting you know to renew. If you do not renew by the deadline, you may lose your Medicaid coverage.

**Keep your health coverage!** Renew your family's IA Health Link or Hawki benefits each year with these simple steps.

1. **Step 1: Watch your mail**
   You will receive a renewal form from the Iowa Department of Health and Human Services (HHS).
   - Look for your form up to 45 days before your coverage will end
   - Moved? Make sure HHS has your current address. Call **(877) 347-5678** if your address has changed

2. **Step 2: Complete the renewal form**
   Complete the renewal form when you receive it:
   - Fill out all the information on each page
   - Be sure to sign the signature page

3. **Step 3: Return the renewal form**
   Return the form to HHS by the due date:
   - Use the prepaid, self-addressed envelope you received with your form.
   - Do not have the envelope? You can mail the renewal form to the image center listed on the renewal form or return it to any HHS office.

- Not sure what you need to do? We can help. Call Molina Member Services at **(844) 236-0894 (TTY: 711)** or call the HHS Contact Center at **(855) 889-7985**.

## Changes in Your Coverage

Major life changes can affect your eligibility with Molina. It is important to let HHS and Molina know when you have these life changes. If you have a major life change, please call the HHS Call Center at **(877) 347-5678** and Molina at **(844) 236-0894 (TTY: 711)**.

Some examples of major life changes are:

- Changing your name
- A change in your health insurance
- If you add or lose other insurance coverage
- If you are added to or removed from someone else's insurance
- Changing jobs
- Your ability or disability changes
- Your family changes. This might mean your family got bigger because of a birth or a marriage. Or your family got smaller. This may be because a family member passed or moved away.
- Changes in your income or assets
- If you become pregnant. Call Molina if you are pregnant. We have special help for you and your baby. Contact Member Services at **(844) 236-0894 (TTY: 711)**

### Change in Benefits

Sometimes, Molina may need to change your covered services or our network providers and hospitals. Iowa HHS may also change the covered services that we arrange for you. If any of these changes happen, we will send you a letter telling you about changes to your plan benefits or providers.

### Notice of Significant Change About Your Primary Healthcare Provider (PCP)

Your Primary Care Provider's (PCP) office may move, close or leave our plan. If this happens, we will tell you within 15 days of the change. We can help you pick a new PCP and send you a new ID card. Call Molina Member Services at **(844) 236-0894 (TTY: 711**).

# IA Health Link

Most members who get health coverage from Iowa Medicaid are enrolled in the IA Health Link managed care program. A Managed Care Organization, or MCO, is a health plan that coordinates your care. Molina Healthcare of Iowa is your MCO. The benefits you receive from Molina depend on the type of Medicaid coverage you have.

To learn more about the benefits and services you may be able to get, refer to the 'Covered Benefits and Services' section of this handbook.

# Iowa Health and Wellness Plan

The Iowa Health and Wellness Plan provides health coverage at low or no cost to Iowans. Members are between the ages of 19 and 64. Eligibility is based on household income.

To learn more about the benefits and services you may be able to get, refer to the 'Covered Benefits and Services' section of this handbook.

## Healthy Behaviors for Iowa Health and Wellness Plan Members

Members in the Iowa Health and Wellness Plan can get free* healthcare if they complete what are known as Healthy Behaviors. To participate in the Healthy Behaviors program and avoid monthly payments after the first year, each year Iowa Health and Wellness Plan members must:

**1. Get a Wellness Exam -OR- Get a Dental Exam**

**AND**

**2. Complete a Health Risk Assessment**

### Monthly Contributions

- Members will receive free* health coverage under the Iowa Health and Wellness Plan in their first year of eligibility.
- Members must complete their Healthy Behaviors in their first year, and every year after, to continue to receive free health services for the following year.
- Members who do not complete their Healthy Behaviors every year may be required to pay a small monthly contribution that depends on their family income. Monthly contributions are set by the Iowa health and Human services and are either $5 or $10 dependent on a member's family income.
- Members who do not complete their Healthy Behaviors and do not pay their monthly bill after 90 days, depending on their income, may be disenrolled from the Iowa Health and Wellness Plan.
- Questions about contributions can be made to Iowa Medicaid Member Services at **(800) 388-8366**, 8 am-5pm Monday-Friday.

* There are very few, or no, costs for the first year and very few costs after that. A small monthly payment may be required based on income. There may be an $8 co-pay for using the emergency room for non-emergency services.

### Wellness Exam

In a wellness exam, your health care provider will do things like check your blood pressure and pulse, listen to your lungs with a stethoscope, recommend preventative screenings or take a blood sample to check your cholesterol.

### Dental Exam

In a dental exam, your dentist will go over your dental health. You may receive a cleaning or basic X-rays.

**Health Risk Assessment (HRA)**
In addition to your Wellness Exam -OR- Dental Exam, you must also complete a Health Risk Assessment. Set aside 15 to 40 minutes to complete a survey that asks questions about your health and your experience in getting health services.

To complete your HRA contact Molina Member Services: **(844) 236-0894 (TTY: 711)**.

**Financial Hardship**
If you are unable to pay your contribution, you may check the hardship box on your monthly statement and return the payment coupon OR call the Iowa Medicaid Member Services at **(800) 338-8366**. Important: Claiming financial hardship will apply to that current month's amount due only. You will still be responsible for amounts due from past months. You will also be responsible for amounts due in future months unless you claim hardship in those months. Any payment that is more than 90 days past due will be subject to recovery and, depending on your income, you may be disenrolled.

## Hawki

The Healthy and Well Kids in Iowa (Hawki) program offers health insurance to children who have no other health insurance. Members are under 19 years of age. Eligibility is based on household income. No family pays more than $40 per month. Some families pay nothing at all

To learn more about the benefits and services you may be able to get, refer to the 'Covered Benefits and Services' section of this handbook.

# Covered Benefits and Services

## Medical Benefits

As a member of the Molina, you will receive a variety of medical benefits and services. Some services may require prior approval. Please work with your healthcare provider to determine if the specific service you need is covered. You may contact Molina to find providers you can see for your medical care described below by calling Member Services at **(844) 236-0894 (TTY: 711)**.

We have a growing family of doctors and hospitals. **They are ready to serve you.**
Below is a summary of the healthcare services and benefits you have access to.

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| | Covered | Covered | Covered |
| **Preventive Services** | | | |
| Affordable Care Act (ACA) preventive services | ✓ | ✓ | ✓ |
| Routine check-ups | ✓ | ✓ limitations may apply | ✓ |
| Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) | ✓ | ✓ up to age 21 | |
| Immunizations | ✓ | ✓ limitations may apply | ✓ limitations may apply |
| **Professional Office Services** | | | |
| Primary Care Provider | ✓ | ✓ | ✓ |
| Office visit | ✓ | ✓ | ✓ |
| Allergy testing | ✓ | ✓ | ✓ |
| Allergy serum and injections | ✓ | ✓ | ✓ |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Certified nurse midwife services | ✓ | ✓ | ✓ |
| Chiropractor | ✓ limitations may apply | ✓ limitations may apply | ✓ limitations may apply |
| Contraceptive devices | ✓ | ✓ | ✓ |
| | | | |
| Family planning and family planning related services | ✓ | ✓ | ✓ |
| Gynecological | ✓ | ✓ limitations may apply | ✓ |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| **Injections** | ✓ limitations may apply | ✓ limitations may apply | ✓ limitations may apply |
| **Laboratory tests** | ✓ | ✓ | ✓ |
| **Child care medical services** | ✓ up to age 21 under | | |
| **Newborn child: office visits** | ✓ | ✓ | ✓ |
| **Podiatry** | ✓ Routine foot care is not covered unless it is part of a member's overall treatment related to certain healthcare conditions. | ✓ Routine foot care is not covered unless it is part of a member's overall treatment related to certain healthcare conditions. | ✓ Routine foot care is not covered unless it is part of a member's overall treatment related to certain healthcare conditions |
| **Routine eye exam One routine vision exam per calendar year.** | ✓ | ✓ | ✓ |
| **Routine hearing exam One routine vision exam per calendar year.** | ✓ | ✓ | ✓ |
| **Specialist office visit** | ✓ PCP referral may be required | ✓ PCP referral may be required | ✓ PCP referral may be required |
| Inpatient Hospital Services | | | |
| **Preapproval of inpatient admissions** | ✓ Required for non-emergent admissions | ✓ Required for non-emergent admissions | ✓ Required for non-emergent admissions |
| **Room and board** | ✓ | ✓ | ✓ |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Inpatient physician services | ✓ includes anesthesia | ✓ includes anesthesia | ✓ |
| Inpatient supplies | ✓ | ✓ | ✓ |
| Inpatient surgery | ✓ | ✓ | ✓ |
| Bariatric surgery for morbid obesity | ✓ | ✓ Covered if member has been determined to be medically exempt | ✓ limitations may apply |
| Breast reconstruction, following breast cancer and mastectomy | ✓ | ✓ | ✓ limitations may apply |
| Organ/bone marrow transplants | ✓ limitations may apply | ✓ limitations may apply | ✓ limitations may apply |
| **Outpatient Hospital Services** | | | |
| Abortions | ✓ Certain circumstances must apply | ✓ Certain circumstances must apply | ✓ Certain circumstances must apply |
| Ambulatory surgical center | ✓ includes anesthesia | ✓ includes anesthesia | ✓ includes anesthesia |
| Chemotherapy | ✓ | ✓ | ✓ |
| Dialysis | ✓ | ✓ | ✓ |
| Outpatient diagnostic lab, radiology | ✓ | ✓ | ✓ |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| **Emergency Care** | | | |
| Ambulance | ✓ | ✓ | ✓ |
| Urgent care center | ✓ | ✓ | ✓ |
| Hospital emergency room | ✓ | ✓ $8.00 per visit for non-emergent medical services | ✓ Emergency services for non-emergent conditions are subject to a $25 copay if the family pays a premium for the Hawki program |
| **Transportation Services** | | | |
| Emergency medical transportation | ✓ Emergency transportation is subject to review for medical necessity | ✓ Emergency transportation is subject to review for medical necessity | ✓ Emergency transportation is subject to review for medical necessity |
| Non-Emergency Medical Transportation | ✓ | ✓ Covered if a Member has been determined to be medically exempt. | |
| **Behavioral Health Services** | | | |
| Assertive Community Treatment (ACT) | ✓ | ✓ Covered if member has been determined to be medically exempt. | |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Behavioral Health Intervention Services (BHIS), including applied behavior analysis | ✓ | ✓ Residential treatment is covered if member has been determined to be medically exempt | |
| (b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment) | ✓ | ✓ Covered if member has been determined to be medically exempt | |
| Inpatient mental health and substance abuse treatment | ✓ | ✓ limitations may apply | ✓ |
| Office visit | ✓ | ✓ | ✓ |
| Outpatient mental health and substance abuse | ✓ | ✓ | ✓ |
| Psychiatric Medical Institutions for Children (PMIC) | ✓ | ✓ For 19 to 20 year olds. Limitations may apply | |
| Crisis Response and Subacute Mental Health Services | ✓ | ✓ Covered if member has been determined to be medically exempt. | ✓ |
| **Outpatient Therapy Services** | | | |
| Cardiac rehabilitation | ✓ | ✓ | ✓ |
| Occupational therapy | ✓ | ✓ Limited to 60 visits per year | ✓ |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Oxygen therapy | ✓ | ✓ Limited to 60 visits in a 12-month period | ✓ |
| Physical therapy | ✓ | ✓ Limited to 60 visits per year | ✓ |
| Pulmonary therapy | ✓ | ✓ Limited to 60 visits per year | ✓ |
| Respiratory therapy | ✓ | ✓ Limited to 60 visits per year | ✓ |
| Speech therapy | ✓ | ✓ Limited to 60 visits per year | ✓ |
| **Radiology Services** | | | |
| Mammography | ✓ | ✓ | ✓ |
| Routine radiology screening and diagnostic services | ✓ | ✓ | ✓ |
| Sleep study testing | ✓ | ✓ Sleep apnea diagnostic services only | ✓ |
| **Laboratory Services** | | | |
| Colorectal cancer screening | ✓ | ✓ | ✓ |
| Diagnostic genetic testing | ✓ | ✓ | ✓ |
| Pap smears | ✓ | ✓ | ✓ |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Pathology tests | ✓ | ✓ | ✓ |
| Routine laboratory screening and diagnostic services | ✓ | ✓ | ✓ |
| Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing | ✓ | ✓ | ✓ |
| **Durable Medical Equipment (DME)** | | | |
| Medical equipment and supplies | ✓ | ✓ | ✓ |
| Diabetes equipment and supplies | ✓ | ✓ limitations may apply | ✓ |
| Hearing aids | ✓ | ✓ for ages 19 to 20, limitations may apply | ✓ |
| Orthotics | ✓ limitations may apply | | ✓ limitations may apply |
| Breast Pumps | ✓ limitations may apply | ✓ limitations may apply | |
| **Long-Term Services and Supports (LTSS) - Community-Based** | | | |
| Case management | ✓ for individuals with a developmental disability and HCBS waiver populations only | | |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Section 1915(C) Home- and Community-Based Services (HCBS) | ✓ | | |
| Section 1915(I) Habilitation Services | ✓ | ✓ Covered if member has been determined to be medically exempt. | |
| Private duty nursing/ Personal cares per EPSDT authority | ✓ Covered up to age 21 under EPSDT | ✓ Covered up to age 21 under EPSDT | |
| Chronic Condition Health Homes | ✓ | ✓ Covered if member has been determined to be medically exempt. | |
| Integrated Health Homes | ✓ | ✓ Covered if member has been determined to be medically exempt. | |
| **Long-Term Services and Supports (LTSS) - Institutional** | | | |
| ICF/ID (Intermediate Care Facility for individuals with Intellectual Disabilities) | ✓ limitations may apply | | |
| ICF/MC Intermediate Care Facility for Medically Complex | ✓ limitations may apply | | |
| Nursing Facility (NF) | ✓ | | |
| Nursing Facility for the Mentally Ill (NF/MI) | ✓ | | |

| Services | Medicaid | Iowa Health and Wellness Plan (IHAWP) | Hawki |
|---|---|---|---|
| Skilled Nursing Facility (SNF) | ✓ | ✓ limitations may apply limited to 120 day stays | |
| Skilled Nursing Facility Out of State (Skilled preapproval) | ✓ limitations may apply | | |
| Community-Based Neurobehavioral Rehabilitation Services | ✓ | ✓ medically exempt only | |
| **Hospice** | | | |
| Hospice | ✓ | ✓ limitations may apply | |
| **Home Health** | | | |
| Private duty nursing/ Personal cares per EPSDT authority | ✓ up to age 21 under EPSDT | ✓ up to age 21 under EPSDT | |
| Home Health Aide | ✓ | ✓ | ✓ |
| Skilled Nursing | ✓ | ✓ | ✓ |
| Occupational Therapy (OT) | ✓ | ✓ | ✓ |
| Physical Therapy (PT) | ✓ | ✓ | ✓ |
| Speech-Language Pathology | ✓ | ✓ | ✓ |

The list above does not show all your covered benefits. To learn more about your benefits, call Member Services at **(844) 236-0894 (TTY: 711)**. If you are an Iowa Health and Wellness Plan member who is determined by Iowa Medicaid to be medically exempt, you will qualify for IA Health Link benefits.

**Prior Authorizations**
Some services and benefits require prior approval. This means your provider must ask Molina to approve those services or benefits before you get them. We may not cover the service or drug if you do not get approval. Molina wants to make sure that you receive the right type and amount of services to help with any condition you may have.

If there are services that were approved before your coverage starts with Molina, those services will still be approved for the first 90 days you are enrolled in Molina, whether an in-network or out-of-network provider asked for the approval.

After the first 90 days you are enrolled with Molina, if you wish to keep getting services from an out-of-network provider, or if the services require prior approval, the provider must ask us to approve them before you can get these services.

These services do not require prior approval and/or a referral from your primary care provider:

- Emergency services.
- Post-stabilization care (care provided after emergency treatment).
- Urgent care
- Family planning Services
- Out-of-network providers need Molina approval (except for family planning services).
- Routine provider visits with in-network providers (some tests or procedures may require prior approval).
- Certain behavioral health and substance use disorder services (Ask your provider if prior approval is needed).

If you have questions about an approval request, call Member Services at **(844) 236-0894 (TTY: 711)**.

If Molina denies a request for you to get a service, these decisions are called "Adverse Benefit Determinations". You have the right to ask us to appeal our decision. An appeal is a request for Molina to review a decision we made about a service that was denied, reduced, or limited.

Examples of this would be:

- Denied requested care or services.
- Approved a smaller amount of a service than you asked for.
- Ends a service or care that was approved before.

You will get a letter in the mail that will tell you why that decision was made. If you do not agree with a decision, you have 60 calendar days from the date on the letter you received to ask for an appeal. You can ask to file the appeal by phone or in writing.

## Vision Benefits

| Vision Services | | | |
|---|---|---|---|
| **Exams:** | ✓<br>1 complete preventive eye exam every 12 months | ✓<br>1 complete preventive eye exam every 12 months | ✓<br>1 complete preventive eye exam every 12 months |
| **Eyewear:** | ✓<br>**Age 1 and under:** up to 3 pairs of eyeglasses every 12 months, up to 16 gas permeable contact lenses every 12 months<br>**Age 1–3:** up to 4 pairs of eyeglasses every 12 months, up to 8 gas permeable contact lenses every 12 months<br>**Age 4–7:** 1 pair of eyeglasses every 12 months, up to 6 gas permeable contact lenses every 12 months<br>**Age 8 and over:** 1 pair of eyeglasses every 24 months, 2 gas permeable contact lenses every 24 months | ✓<br>**Age 19 and 20 only:** 1 pair of eyeglasses (frames and lenses) every 24 months | ✓<br>$100 retail allowance toward eyeglasses and contact lenses every 12 months |
| Repairs: | ✓<br>$100 retail allowance toward eyeglasses and contact lenses every 12 months | ✓<br>**Age 19 and 20 only:** replacement for eyeglasses lost or damaged beyond repair is not limited | Not covered |

## Transportation Benefits

You can get free rides to and from your medical visits. Just call Access2Care at **(866)-849-2062**. Please call at least 48 hours in advance before your appointment to schedule a ride.

- Appointments can be in or out of the community where you live.
- Callers should be age 16 or older.
- Members ages 11 and younger must ride with a parent or guardian.
- Members ages 12–16 must ride with a parent or guardian unless Access2Care has a signed Minor Consent form on file. Call Access2Care for a copy of the Minor Consent form.
- Pregnant members of any age and emancipated minors can ride without a Minor Consent form.
- Rides must be set up at least 48 hours prior to the appointment.

**Note:** Nursing homes are responsible for Non-Emergency Medical Transportation (NEMT) trips within a 30-mile radius of the nursing home. If you are a nursing home resident and need to see a doctor less than 30 miles from your location, your nursing home should provide transportation.

## Dental Benefits

Molina only covers dental procedures done in a hospital setting.

**Dental Wellness Plan Kids:** Effective July 1, 2021, dental services are available to Iowa Medicaid members age 18 and younger through a dental carrier as part of the Dental Wellness Plan (DWP) Kids program. These services are not part of those provided by Molina. For questions about your dental benefits, call Iowa Medicaid Member Services at **(800) 338-8366** or visit: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/dental-wellness-plan**
**Hawki Dental:** Dental services are available to Hawki members through a dental carrier. The services are not part of those provided by Molina. For questions about your dental benefits, call Hawki Customer Service at **(800) 257-8563**.

**Dental Wellness Plan:** The Dental Wellness Plan provides dental coverage for adult Iowa Medicaid members aged 19 and older. The services are not part of those provided by Molina. Dental coverage is provided by a dental carrier. For questions about your dental benefits, call Iowa Medicaid Member Services at **(800) 338-8366** or visit **hhs.iowa.gov/programs/programs-and-services/dental-and-oral-health/i-smile**: I-Smile is a statewide program that connects children and their families to local dental and medical providers within the Medicaid provider network. I-Smile coordinators are local dental hygienists available to answer members' dental questions and assist families in finding community resources when accessing dental and/or medical care is difficult. For more information on I-Smile, and to find your local I-Smile coordinator, visit: **hhs.iowa.gov/media/14264/download?inline=**

# Going to the Doctor

## Picking Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) takes care of all your medical needs. Every Molina member must have a PCP. Your PCP's office is your health home. It is important to have a PCP who makes you feel comfortable. It is easy to choose one with our Provider Directory (a list of providers). You can pick one for you and another for others in your family, or one who sees all of you. You can also call Molina Healthcare at **(844) 236-0894** if you need help making an appointment, finding a provider, or finding information about your PCP.

**You must see a doctor that is part of Molina's provider network**. If you do not choose a PCP, Molina will select one for you. Molina will choose a PCP based on your address, preferred language, and providers your family has seen in the past.

Use our Provider Online Directory to search for the best PCP for you.

If you wish to change your PCP, you can do this on your My Molina Mobile App, or from your desktop. You can also call Member Services at **(844) 236-0894 (TTY: 711)** Monday to Friday from 7:30 a.m. to 6 p.m. (CST). If you change your PCP, we will send you a new ID card.

**Important:** You have unlimited visits to your PCP. There is no cost to you. Make appointments with them when you feel sick. You should also have a wellness check-up every year.

### Find a provider any of these ways:

- Go to: **MolinaProviderDirectory.com/IA**
- Log into **MyMolina.com**
- Use the My Molina mobile app

### Your PCP can be a:

- Family or General Practitioner.
- Internal Medicine.
- Pediatrician.
- Advanced Registered Nurse Practitioner (ARNP).
- Obstetrician or Gynecologist (OB/GYN).
- Physician Assistant
- Attending specialist (for members requiring specialty care for their acute or chronic conditions, or condition related to a disability).
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Indian Tribe, Tribal Organizations or Urban Indian Organization.

### Direct access services

You may get some services without seeing your PCP. They are called direct access services. You do not need a referral for these services. Some of these include:

- Visits to an obstetrician (OB), gynecologist or certified nurse midwife
- Family planning services
- Routine and preventive care like prenatal care, breast exams, mammograms, and Pap tests

### An obstetrician and/or gynecologist as a PCP

Female members can see an obstetrician and/or gynecologist (OB/GYN) in our plan for OB/GYN health needs. You also do not need a referral from your PCP to see a plan OB/GYN. These services include:

- Well-woman visits.
- Prenatal care.
- Childbirth
- Postpartum care.
- Care for any female medical condition.
- Family planning (you can also see a provider not in our plan (non-network) for this service).
- Referral to a special provider in our plan.

If you do not want to go to an OB/GYN, your PCP may be able to treat you for your OB/GYN health needs. Ask them if they can give you OB/GYN care. If not, you will need to see an OB/GYN.

While pregnant, your OB/GYN can be your PCP if he or she agrees to. Our nurses can help you decide if you should see your PCP or an OB/GYN. To speak with a nurse, call our 24-hour Nurse Help Line at **(844)-236-2096**.

If you need help picking an OB/GYN, go online to our provider directory at **MolinaProviderDirectory.com/IA** or call Member Services.

### Picking a PCP for your newborn

Expectant moms can choose a PCP for their newborns by calling Member Services at **(844) 236-0894 (TTY: 711)**. If you do not choose a PCP for your newborn, we will assign one for you. You can always choose a new PCP by going online to **MolinaProviderDirectory.com/IA**.

## If you are an American Indian or an Alaskan Native

You may use an Indian Health Services or Tribal 638 provider anytime you wish. You may also choose a PCP from the Molina network that is not an Indian Health or Tribal 638 provider, and Molina will pay for your care.

## Schedule Your First Visit

After you choose your PCP, make an appointment for a wellness visit (a general checkup). This will give you both a chance to get to know each other. It also lets your PCP get to know you when you are well, so they can better treat you when you are not. Call your PCP right away if you need to cancel or reschedule your appointment.

Your PCP will:

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

### What to bring when see your PCP

When you go to your PCP's office for your visit, be sure to bring:

- Your Molina member ID Card
- Any medicines you are currently taking
- Any questions you may want to ask your PCP

If the appointment is for your child, be sure you bring your child's:

- Molina member ID card
- Shot records
- Any medicine he or she is currently taking

### Interpreter Services

If you need to speak in your own language, we can get a translator to talk to you. They can also help you talk to your doctor or provider.

A translator can help you:

- Make an appointment
- Talk with your doctor or nurse
- Get emergency care
- File a complaint, grievance, or appeal
- Get information about taking medicine
- Follow up about prior approval you need for a service
- With sign language

This is a free service. If you need a translator, please call Member Services at **(844) 236-0894, (TTY: 711)**.

# How to Make an Appointment

## Appointment guidelines

When you need to see your doctor, you should be given an appointment within the timeframes listed below.

**When you should get the appointment:**

### Medical Appointment

| Appointment Types | Standard |
|---|---|
| PCP Routine and/or asymptomatic | Within 30 calendar days |
| PCP, persistent symptoms | Within 48 hours |
| PCP, Urgent Care | Within 24 hours |
| PCP, Preventive Care | Within 30 calendar days |
| After Hours Care (Emergency Services) | 24 hours/day; 7 day/week availability |
| Specialty Care (Routine) | Within 30 calendar days |
| Urgent Specialty Care | Within 24 hours |
| Optometry Care Non-urgent | Within 3 weeks |
| Optometry Care Urgent | Within 48 hours |
| Lab and X-Ray Non-urgent | Within 3 weeks |
| Lab and X-Ray Urgent | Within 48 hours |

### Behavioral Health Appointment

| Appointment Types | Standard |
|---|---|
| Life Threatening Emergency | Immediately |
| Non-Life-Threatening Emergency | Within 6 hours |
| Mobile Crisis | Within 1 hour |
| Urgent Care | Within 1 hour of presentation at service delivery site or within 24 hours of telephone contact request |

| | |
|---|---|
| Persistent symptoms | Seen or referred to appropriate Provider within 48 hours of reporting symptoms |
| Initial and/or Routine Care Visit | Within 10 business days of request and follow up within 30 calendar days |
| Substance Use Disorder & Pregnancy (Pregnant and in need of SUD services) | Admitted within 48 hours of seeking treatment |
| Intravenous drug-use | admitted not later than 14 days after request for admission, or 120 days after request if no program has capacity and interim services are made available within 48 hours |

### Second Opinion

If you do not agree with your provider's plan of care, you have the right to a second opinion. You may talk to another network provider. In some cases, we will arrange for you to talk to a provider outside our network at no cost to you. To learn more, call Member Services at **(844) 236-0894 (TTY: 711)** Monday to Friday 7:30 a.m. to 6:00 p.m.

## Specialists

There may be times when you need to see a specialist. You have the right to choose specialists within the Molina network. Your primary care provider (PCP) will help you choose a specialist and refer you.

## In Office Laboratory Tests

Molina limits the number of lab tests that may be performed in the Provider's office. The reason is for quality purposes. All other lab testing must be referred to one of Molina's In-Network Lab Providers. Visit **MolinaHealthcare.com/IA** to find a list of lab services allowed in a Provider's office. Specimen collection is allowed in any Provider's office. Please note Molina will not pay claims for lab services not listed on the website.

# Pharmacy

## Prescriptions

You get prescription drugs at little to no cost to you. We cover your medically necessary medicines and prescribed drugs. We also cover some over the counter (OTC) medicines with a prescription from your provider (see the section 'Over the Counter Medicines' to learn more). Generic drugs are drugs that have the same dosage, safety, strength and intended use as a brand-name drug. They usually cost less than brand-name drugs. We cover all drugs covered by Iowa Medicaid. Iowa Medicaid uses a Preferred Drug List (PDL). Our PDL includes both generic and brand-name drugs. It also gives you facts about a drug and lists any restrictions on them. To fill your prescriptions, you must use a network pharmacy. Be sure to take your member ID card with you. Be sure to fill your prescriptions before you travel out of state.

Most medications are covered up to a one-month supply, with the exception of some contraceptives. Some contraceptives are covered up to a 3-month supply.
If the medication requires prior authorization, for some medications, you may receive an emergency supply of the medication while the prior authorization is being reviewed. Refer to the Iowa Medicaid PDL or call Molina Member Services at our toll-free number **(844) 236-0894 (TTY: 711)**.

To find a network pharmacy, see our Provider Directory at **MolinaProviderDirectory.com/IA**.
You can also call Member Services at **(844) 236-0894 (TTY: 711)**.

**You can find the link to the Iowa Medicaid PDL on our website at MolinaHealthcare.com/IA under the Pharmacy section in Benefits and Services.**

Some drugs have limits, or rules, on their use due to cost, safety and other reasons. These might include:

- Quantity limits –limits the amount of the drug you can fill or refill at a given time or interval.
- Step therapy – requires that you try a certain drug, such as a generic, before your provider can prescribe another drug.
- Prior authorization – means your provider must get approval from Molina before prescribing a drug.

Some reasons for a prior authorization (PA) include:

- You need a drug that is non-preferred on our PDL.
- The drug is being used for a health condition the Food and Drug Administration (FDA) did not approve it for.
- The prescription is being refilled too soon (quantity limits).
- There are other drugs you must try first (step therapy).
- There is a generic or alternative drug available.
- The drug can be misused or abused.
- To get approval, your provider must tell us the medical reason you need the drug and quantity. We will work with your doctor to help you get the drugs that are best for you!
- If we do not approve a PA request, we will send you a letter. The letter will explain how to file an appeal. It will also tell you about your right to a state hearing. Learn more about appeals in the section titled 'Grievances and Appeals'.

Our PDL can change. Check the PDL when you need to fill or refill a medicine.

### Over-the-Counter (OTC) Medicines

We cover some over-the-counter (OTC) medicines with a prescription from your provider. Please check our Preferred Drug List (PDL) on our website **MolinaHealthcare.com/IA** under pharmacy or call Member Services at **(844) 236-0894 (TTY: 711)** to see which OTC medicines are covered. We also have the option to order up to $30 per quarter per family of over-the-counter medications and medical supplies through Nations OTC. You can call for services at **(877) 391-6245** or access their services at **molinaia.nationsbenefits.com**.

#### Copays

Molina does not charge members any copayments for pharmaceuticals; however, you may be responsible for a copay for other services. Please see your Molina ID card for your current copayments.

## Emergency and Urgent Care

### Emergencies

The emergency room (ER) is used when you think a medical problem risks your life or health if you do not get treated right away. The ER staff will decide how quickly you will be seen. It will be based on your medical needs. You do not need a prior authorization to visit the ER. You may use any hospital for emergency care.

#### Some examples of when to use the ER:

- Bad cuts or burns
- Chest pain
- Head or eye injuries

- Danger of loss of life or limb such as a leg or arm
- Blackout
- Choking
- Heavy bleeding
- Loss of speech
- Possible broken bones
- Overdose

## Urgent Care

Urgent care centers are a great option if you need care after hours.

### Some examples of when to use the urgent care center:

- Severe cold or flu symptoms
- Ear pain
- Sore throat
- Stomach flu or virus
- Wound that needs stitches
- Sprains, strains, or deep bruises

## Hospital Services

If you need to visit the hospital for a non-emergency, you must first get a referral from your PCP or specialist. If you have questions about your hospital visit, please talk to the provider who referred you.

## Routine Care

As a Molina member, your PCP will get to know your health history, take care of your basic medical needs, and make referrals when you need them. Routine care is care that is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment. You should call your PCP to schedule routine care. If you go to the emergency room for these types of services, you may be required to pay a copayment for the services you get there.

### Post-stabilization Care

Post-stabilization services are services you need after an emergency. These services help get your health back to normal. These services are important and help make sure you do not have another emergency. Post-stabilization services are covered and subject to prior authorization requirements.

# Member Costs

## Copays

A copayment is a set dollar amount you pay when you get certain services or treatment. It is your share of the cost for a covered healthcare service.

A copayment may be required for **non-emergency** use of a hospital Emergency Room (ER).

- Iowa Health and Wellness Plan members may be charged an $8 copayment for each visit to the emergency room that is not considered an emergency.
- Hawki members may be charged a $25 copayment for each visit to the emergency room that is not considered an emergency.

**There are no other copays under your Molina health plan.**

Before providing non-emergency services and imposing copayments, the hospital providing care must:

1. Conduct an appropriate medical screening to determine that the Member does not need emergency services.
2. Inform the Member of the amount of his or her copayment obligation for non-emergency services provided in the hospital ER.
3. Provide the Member with the name and location of an available and accessible alternative non-emergency services provider.
4. Determine that the alternative provider can provide services to the Member in a timely manner with no copayment.
5. Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the Member is advised of the available alternative provider and of the amount of the copayment and chooses to receive treatment for a non-emergency condition at the hospital ER, the hospital will assess the copayment.

You will not be charged a copay for emergency services for emergency conditions.

**Copayments do not apply to the following member groups:**

- Individuals under the age of 18
- Pregnant members (throughout pregnancy and postpartum period 60 days following end of pregnancy)
- Individuals receiving hospice care
- Children in foster care
- Disabled children under the Family Opportunity Act
- Breast and Cervical Cancer Care Program
- Federally recognized American Indians/Alaska Natives

## Member Liability/ Client Participation

You may have to pay for services that are not covered. You may also have to pay for services from providers who are not in our network. If the services are an emergency, you do not have to pay. If you need help, call Member Services.

Molina offers extra benefits to eligible members. These extra benefits are called value-added services. Log in to **MyMolina.com** or call Member Services at **(844) 236-0894 (TTY: 711)** to learn more about these benefits.

### We offer the following:

**MyMolina.com: Manage your health plan online 24/7**
Connect to our secure portal from any device, wherever you are. Change your doctor, update your contact information, request a new ID card, claim your Healthy Rewards, and much more. To sign up, visit **MyMolina.com**.

**Health education for chronic conditions and healthy lifestyles**
Live well and stay healthy! Our free programs can help you control your weight, stop using tobacco or get help with chronic conditions. You get helpful materials, care tips and more. If you have asthma, COPD, diabetes, heart problems, depression, or want to lose weight or quit tobacco, one of our nurses or Care Managers may contact you. You can also call our Health Management Department at **(866) 472-9483 (TTY: 711)** to sign up for one of our programs.

**Pregnancy Rewards Program**
Are you having a baby? We are here to help you have a healthy pregnancy and healthy baby. Our Pregnancy Rewards program lets you earn gift cards for completing healthy activities, like getting prenatal checkups. It is easy! Sign up at our secure portal, **MyMolina.com**. You can also request any Healthy Beginnings pregnancy information by calling Member Services at **(844) 236-0894 (TTY: 711)**.

**Transportation**
Lean on Molina for enhanced transportation benefits. Members need to request these services from their Care Coordinator or by calling Access2Care at **(866) 849-2062 (TTY: 711)** at least 2 business days before you need a ride.

**Access to community services**
We provide four one-way rides to foodbanks, grocery stores, farmers markets, Women, Infants, and Children (WIC) appointments, job training and interviews. We also offer transportation to your local YMCA.

To use this benefit, call Access2Care at **(866) 849-2062** at least two days before you need a ride.

**Medical appointments**
"Non-medically exempt" Iowa Health and Wellness members and Hawki members at least 16 years old qualify for four one-way rides to medical appointments at no cost through Molina's Value-Added Benefit. Molina Healthcare will also cover emergency transportation to the hospital. You should call **911** when you have an emergency and need immediate transportation.

**Caregiver transportation**
Molina knows it's important for you to stay connected to your family and caregivers when you're in a facility setting. We'll give your caregiver (parent, child or direct caregiver) four one-way rides per month to visit you while you're in the facility. Call Access2Care at **(800) 849-2062** at least two days before you need a ride.

**Molina Mobile App**
Manage your health care anytime, anywhere. Members can sign into the app using their My Molina User ID and Password to access secure features including:

- View your member ID card.
- Find a provider or facility near you with the Provider Finder.
- Message your health plan questions.
- Get important health reminders.
- Use the Nurse Advice Line to get the care you need.
- Access your medical records.
- You can download the app for free on your smartphone using the App Store for Apple and Google Play for Android.

**No-cost cell phone service**
As a Molina member, you get a free wireless service. Free talk, free text, free international calling and up to 4.5 GB of data. Learn more at **truconnect.com/molina**.

**Community Resources**
We are part of your community. And we work hard to make it healthier. Local resources, health events and community organizations are available to you. They provide great programs and convenient services.

Best of all, most of them are free or at low cost to you.

- **MolinaHelpFinder.com** powered by Aunt Bertha. This is a free and confidential service that will help you find local resources. Available 24/7.

Molina offers additional benefits to support your health and wellness, if you have any questions about these services, Call Molina Member Services toll-free at **(844) 236-0894 (TTY:711)**.

# Value-Added Services

## Molina Value Added Services Table

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| **Baby showers** | Attend a Molina baby shower (virtual or in-person). | Pregnant Members and their guests up to two additional family members | $100 Healthy Rewards Gift Card/Incentive for pregnant members attending a Molina Baby Shower |
| **Healthy Rewards** | Complete up to eight well-child visits on time within a 30-month period (6 visits between 0-15 months; 2 visits between 15-30 months). | Members newborn to 30-months old | $10 Healthy Rewards Gift Card per Well-child Visit: <30 mos. (Max $80) |
| | Complete yearly well-child visit for children and teens between 3 and 21 years old. | Members between ages 3 and 21 years old | $25 Healthy Rewards Gift Card for Well-Child Visits: >3 Years Old (once per calendar year) |
| | Complete a follow up visit (includes telehealth) with a **Behavioral Health Provider** within seven (7) days of discharge from an inpatient Behavioral Health hospital stay. | All Members | $50 Healthy Rewards Gift Card for completing a **Behavioral Health** follow-up visit **within seven (7) days** after discharge for **each** Behavioral Health inpatient hospital stay. |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| | Complete a follow-up visit (included telehealth) with **your Primary Care Provider/ Clinic** within seven (7) days of discharge from an inpatient hospital stay related to chronic health conditions. | All Members | $50 Healthy Rewards Gift Card for completing a **Primary Care** follow-up visit **within seven (7) days** after discharge for **each** chronic health inpatient hospital stay. |
| | Complete yearly adult well visit (physical) | Members aged 18 and older | $25 Healthy Rewards Gift Card for Adult Well Visit (annual physical) (Once per calendar year) |
| | Complete initial or annual health risk screenings, limited to one per year. | All Members | $25 Healthy Rewards Gift Card for completing your Health Risk Screening (Once per calendar year) |
| | Attend postpartum visit 7–84 days after the birth of the baby. | Members ages 12 and older who have recently given birth | $75 Healthy Pregnancy Rewards Gift Card for Postpartum Visit (Once per pregnancy) |
| | Complete a prenatal visit during their first trimester (first 3 months of pregnancy) or within 42 days after enrollment. | Members ages 12 and older who are newly pregnant | $75 Healthy Pregnancy Rewards Gift Card (One per baby if pregnant with multiples) |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| | Complete a cervical cancer screening (pap test) based on screening guidelines | Female Members ages 21–64 | $25 Healthy Rewards Gift Card for Cervical Cancer Screening (Once per calendar year) |
| | Complete a yearly chlamydia screening | Female Members ages 16–24 | $25 Healthy Rewards Gift Card for Chlamydia Screening (Once per calendar year) |
| | Complete yearly mammogram screening | Female Members ages 40–74 | $25 Healthy Rewards Gift Card for Mammogram<br><br>(Once per calendar year) |
| | This benefit provides over-the-counter tobacco cessation products for qualified Members. Providers may make referrals for program participation. Upon approval, this program will be facilitated through our Member Services department. | Eligible Members aged 18 or older, or pregnant women of any age | for Smoking Cessation Products ($185 value at no cost to Member)<br><br>Earn up to $60 in Healthy Rewards for completing the Quitline Tobacco Cessation program. |
| | Members who receive approval from the health plan can receive up to 13 weeks of WW services; can be referred by Providers, internal departments (care managers, etc.), or self-referral. | All Members | Obesity/WW® (formerly Weight Watchers) ($45 value at no cost to Member) |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| | Complete yearly diabetic retinal eye exam and complete HbA1c lab work. | Members ages 18–75, diagnosed with diabetes | $25 Healthy Rewards Gift Card for Diabetes Eye Exam or A1C test ($50 total if both completed) (Once per calendar year for both) |
| **Doula Services- Through enrolled Doula providers such as the Iowa Black Doula Collective** | Members (at high risk or members of a group experiencing health disparities, particularly Black women) may request doula assistance during labor and delivery to provide emotional and physical support to the laboring mother and her family. | Pregnant Members meeting high-risk criteria | 8 Doula visits per member |
| **Over the counter medication- Including pregnancy tests- Through pharmacy providers** | Members can receive up to $30 per Member household, per quarter for commonly used over-the-counter items not covered through the Medicaid pharmacy benefit. | All Members | Over-the-Counter Medications |
| **Diabetes** | Molina provides each Member with a glucometer at no cost to help them with the day-to-day management of their insulin levels, help them reduce episodes of severe hypoglycemia, and empower self-care. | Members with Type 2 diabetes | Glucometer and Test Strips for the Insulin and Blood Glucose Program |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| **YMCA Membership** | Molina provides members who have completed their annual physical or well-child visit with a membership to their local YMCA. | Must complete an annual physical or well-child visit | Three-month membership |
| **Can Play Membership** | To assist our young Members with complex needs in developing social and leadership skills. | Qualified Members under the age of 19 | Sponsored Membership Fees |
| **Additional Transportation** | Additional transportation including family members—Members may receive transportation to certain medical and Social Determinants of Health (SDOH) resources and may have their children/family attend Provider visits. Members need to request these services from their Care Coordinator or by calling the Member Services helpline. | All Members | Provides transportation to medical, vision, and behavioral health visits, food banks, grocery stores, farmers markets, Women, Infant, Children (WIC), domestic violence agencies, public assistance appointments, housing authority and job training, interviews, and more |
| **Home Delivered Meals for High-Risk Pregnant Women-Through Mom's Meals** | Molina will provide home delivered meals, including medically tailored meals, to Members experiencing food insecurity and high-risk pregnancy. | For high-risk pregnant members | Home meal delivery 2 meals a day for 14 days. Case manager referral needed. |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| **GED/HiSET Testing** | Vouchers to take GED/ HiSET test for free at authorized testing centers ($134 value). | Members ages 18 years and older | $134 value at no cost to member<br><br>(Once per lifetime) |
| **GED/HiSET Exam pass** | Gift card for passing exam. Exam must be completed while member is enrolled with Molina. | Member ages 18 years and older | $25 Healthy Rewards Gift Card (Once per lifetime) |
| **TruConnect** | Members who qualify for the federal Lifeline program will receive free wireless service plans. The free service plan supported by TruConnect includes unlimited talk/text and free international calling to Mexico, Canada, China, Vietnam and South Korea. Also, up to 4.5 GB of free data. | Members who qualify for the Federal Lifeline program | Free -no cost to member |
| **Community Resource Referral Support Platform** | Provides Members on-demand, 24/7 access from our website and mobile application access to thousands of community resources across the State in the areas of health, financial support, education, emergency resources, legal support, housing, employment opportunities, transportation, and food security. | All Members | Free -no to cost member |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| **My Molina App** | The My Molina app provides Members with a variety of resources, including information about their benefits, Member ID card, list of medications, and Individualized Service Plan. The My Molina mobile app delivers push messages with information about how to close an identified care gap, e.g., reminders that it is time for a preventive visit. With the touch of the screen, Members can connect with their care team. | Members actively enrolled and participating in Molina programs that have communication access barriers | Free -no cost to member |
| **Home-delivered Meals for High-Risk Transitions of Care** | Home-delivered meals for Members discharged from the hospitals who are at high-risk for readmission and would benefit from nutritiously appropriate and consistent meals. | Members over age 18 with high-risk conditions and at high-risk for readmissions | Two meals a day for up to two weeks; delivered once a week. |
| **Community transition move in Basket** | Members transitioning into a community setting can select up to $50 worth of items. | LTSS Members age 21 and older (one lifetime benefit) | $50 worth of items |
| **Caregiver Transportation (long-term care only)** | Monthly trips (for caregivers) to visit a member who is residing in a facility. | Members aged 18 and older living in a long-term care facility | 4 one-way trips for caregivers |
| **Caregiver Support benefit** | Caregiver support benefit for assisting an LTSS Member with completing a preventative visit | LTSS Members | $50 Healthy Reward |

| Program | Member Action | Eligible Populations | Amount/Service Caps |
|---|---|---|---|
| **Healthy Living** | Includes a wide variety of assistive devices and adaptive aids to help Members maintain independence in their homes. Members can select two from the following items to achieve better health: digital scale, home blood pressure cuff, peak flow meter, reachers/grabbers, lumbar pillow, personal fan, clip-on lamp, walker bag, pair of face masks | Members age 21 and older | $60 per member/ lifetime |
| **Pet Care Kenneling** | Members who are hospitalized may qualify for reimbursement of pet kenneling expenses. | Members 18 and older | Up to $500 per member |

# Wellness Care

Your health is important to us. Good health begins with enough sleep, healthy food and healthy behaviors. One of these behaviors is to see your doctor annually (children more frequently) and to follow the advice of your doctor.

## Wellness Care for Adults

Your PCP will tell you when you and your family are due for your checkups. He or she will also remind you when you and your family need certain screenings and immunizations.

To help you stay on top of getting your checkups, we may call you or send you a letter. We do this as a reminder for you. Please keep this in mind if you get a call or letter about your yearly flu shot or your child missing a health check. This is one of the ways we help you and your family stay healthy.

## Wellness Care for Children

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is preventive care for IA Health Link children under the age of 21. Well-child checkups with your primary care provider (your main doctor) or pediatrician are important to help make sure your child is healthy. Visits with your child's doctor can find problems early and treat them before they get worse. You do not need a referral

for these visits. These services are provided at no cost to you. Talk to your doctor about what's right for your child. Many schools, activities, and other organizations require a "sports physical." This is a limited exam. Tell your provider if you need this exam. They can complete the forms you need during your child's well-child checkup.

**Molina has many programs and tools to help keep you and your family healthy, including:**

- Health coaching.
- Care management services.
- Pregnancy care and parenting classes.
- Well-care reminders.

Your provider may suggest one of these programs for you. If you want to know more about these programs, please call Member Services at **(844)-236-0894**.

In addition to services covered by Molina, other services may be available through the following programs: Care for Kids, I-Smile @ School, Behavioral Health Services-School Settings, Title V Maternal and Child Health Services, and Family Planning Services. Please contact Iowa HHS Medicaid Member Services for additional information at **(800) 338-8366**.

# Care for Pregnant Members

We want to make sure you get medical care as soon as you think you are pregnant. If you think you are pregnant, see your PCP. Once you are pregnant, your PCP will want you to see an OB/GYN. You do not need a referral to see an OB/GYN. It is important that you see your OB/GYN. If you need help finding an OB/GYN, call Member Services at **(844) 236-0894 (TTY:711)**. We can help you arrange for your prenatal care.

When you find out you are pregnant, you must also contact Molina Member Services. You should also report your pregnancy to the HHS Contact Center at **(855) 889-7985**.

**When you are pregnant, keep the following in mind:**

- Make sure to see your PCP or OB/GYN throughout your pregnancy.
- Make sure you go to all your visits when your PCP or OB/GYN tells you to.
- Your MCO provides coverage for childbirth and hospital stay.
- Make sure you go to your provider after you have your baby for follow-up care (on or between 7 to 84 days after your baby is born).
- You should choose a pediatrician for your baby before it is born. If you do not choose a pediatrician, Molina will choose one for you.
- Molina does not limit benefits for postpartum hospital stays to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the attending

provider, in consultation with the member makes the decision to discharge the member or the newborn child before that time.

- Molina does not require a provider to obtain prior authorization for stays up to the 48 or 96-hour periods.

There are things you can do to help have a safe pregnancy. Talk to your doctor about medical problems you have, like diabetes and high blood pressure. Do not use tobacco, alcohol or drugs now or while you are pregnant. It is important to have healthy lifestyle habits while you are pregnant. This includes exercising, eating balanced meals, not smoking, and sleeping 8–10 hours a night. These things can help you and your baby stay healthy.

You should see your doctor before you are pregnant if you have had the following problems:

- Three or more miscarriages
- Preterm birth, also known as premature birth, is the birth of the baby at fewer than 37 weeks gestational age
- Stillbirth

You may also talk to your PCP or OB/GYN about birth control options.

Earn rewards for getting prenatal and postpartum care by calling Member Services at **(844)-236-0894** or visit our website at **MolinaHealthcare.com/IA**.

## Doula Services*

A doula is a trained professional who is there to support you and your family emotionally and physically in preparation for labor, during delivery and after the birth of your baby. Doulas work in partnership with your OB/GYN, midwife, or primary care provider to give you support, advocate for you, and keep you at the center of your pregnancy journey.

Doulas can help you:

- Create a birth plan
- Provide emotional support
- Give pregnancy education
- Prepare for postpartum care and,
- So much more!

*Eligibility requirements apply

# Care Management

## Care Connections

Care Connections is a team of nurse practitioners and social workers who can help you manage your health. We will visit you to learn about you and your health needs. We will give you an Annual Comprehensive Exam (ACE) to:

- Take your vital signs.
- Check your hemoglobin A1c and do a diabetic retinal exam (if you have diabetes).
- Talk to you about your current health conditions, and medicines and help decide what you need on an ongoing basis.
- We will visit you in your home, assisted living facility, senior living community or nursing home.

## Should you be in Care Management?

### Care Management could be helpful to you if you:

- Have a chronic care need, i.e., Asthma, Diabetes, COPD
- Have or are at risk for a serious condition
- Have a behavioral health need
- Have a developmental or physical disability
- Have some other special healthcare need
- Have nursing facility level of care needs
- Need Home- and Community-Based Services
- Are using the Self-Directed Community Benefit Services

If you live with chronic conditions, we can help you to get the services you need. You can also call Member Services at **(844) 236-0894 (TTY: 711)**. You may opt out of this program at any time. Just call Member Services.

We will work with you individually to establish a person-centered service plan and allow you to participate in arranging and directing your own care if you wish to do so. We will stop or adjust the plan if it is no longer appropriate, or it does not work. For more information about Care Management or making changes to your currently assigned care management program, you can call Member Services at **(844) 236-0894 (TTY:711)** and ask to speak with Care Management staff. We will help you find the right resources for your needs.

## Complex case management

Sometimes, serious illness or major medical conditions impact you. If this occurs, know that we can help you navigate the healthcare system to obtain the care, services and support you need. You can also call Member Services at **(844) 236-0894 (TTY: 711)**. You may opt out of this program at any time. Just call Member Services.

## Transition of care

When you are discharged from a hospital or nursing home, we have coaches who help you transition. They help you get the care need at home. You can also call Member Services at **(844) 236-0894 (TTY: 711)**. You may opt out of this program at any time.

## Not comfortable with a home visit?

We can also do a video visit if you have a smartphone or computer. Our video assessment allows you to see and talk to a nurse practitioner in real-time. Your call will be private. When you agree to a visit, we can support you better and answer any questions you have about your health.
**There is NO COST to you!**

# Behavioral Health

We cover your behavioral health care. Your behavioral health is an important part of your overall health and wellness.

### We can help you:

- Deal with feelings of sadness or worries, drug and alcohol problems or stress.
- When you need someone to talk to and want to feel better.
- Get an appointment with a doctor.
- Get the information you need about behavioral health services.
- Talk with your doctors about how you are feeling.

### You have behavioral health services available to you.

They include:

- Substance use disorder treatment.
- Outpatient services such as counseling.
- Help with medicines.
- Day treatment.
- Case management.
- Inpatient treatment (if you and your doctor feel that you cannot be safely treated in an outpatient setting).

You do not need a referral from your primary care provider (PCP) to get behavioral health services. But, we encourage you to talk to your PCP about your behavioral health. Your PCP can help make sure you are getting what you need.

### Are you having a crisis?

If you are having a crisis, we can help you. Molina has partnered with Your Life Iowa, the state-wide Crisis Line that supports Behavioral Health (BH), Substance Use Disorder (SUD), gambling,

and other mental health needs and may be accessed by Members 24/7 year-round by contacting 988. You may also call Your Life Iowa 24 hours a day, 7 days a week at **(855) 581-8111**. When you call, a live person will answer the phone and be ready to help you! You can also text at **(855) 895-8398**.

# Long-Term Services and Supports (LTSS)

Long-term services and supports include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver. Molina coverage provides services and supports to meet the behavioral, social, environmental and functional needs of our members who are:

- Part of an HCBS waiver program
- Nursing facility residents
- Skilled nursing facility (SNF) residents
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) residents
- Residents in a nursing facility for the mentally ill (NF/MI)

## Case Management

### The Role of Community-Based Case Managers

The Community-Based Case Manager's (CBCM) main role is to support members and help them access LTSS and other services. The CBCM is responsible for leading the Person-Centered approach to coordinating your services to make sure your needs are met. Service coordination includes but is not limited to:

- Identifying your needs
- Conducting a health assessment
- Deciding a course of action
- Coordinating necessary services

### What can you expect from your LTSS Community-Based Case Manager (CBCM)?

**Your LTSS Community-Based Case Manager will:**

- Conduct face-to-face meetings at your home to assess your physical, behavioral, functional, social, and long-term services and supports needs.
- Include your family members, caregivers and natural supports to help assess your needs, if you approve.
- Work with you, your family members, and natural supports to develop a service plan to address your individual needs identified during your meetings.
- You will receive a comprehensive assessment once a year, or if you have a significant change in your health needs.
- Help coordinate timely access to services.

- Coordinate services that meet your medical and functional needs.

**Molina can help you if you have questions about your benefits and services.** You can reach us Monday through Friday from 7:30 a.m. to 6 p.m. Central time. Call **(844) 236-0894 (TTY 711)**.

## Home and Community-Based Services (HCBS)

Home and Community-Based Services (HCBS) are Medicaid programs that give you more choices about how and where you get services. HCBS are for people with disabilities and older Iowans who need supports to live in their home and community.

### To be eligible for HCBS you must:

- Be eligible for Medicaid
- Need a certain level of care
- Meet the specific requirements of the HCBS waiver for which you are applying

To receive HCBS, you must meet the specific requirements of one of Iowa's eight HCBS programs:

- AIDS/HIV Waiver
- Brain Injury Waiver
- Children's Mental Health Waiver

- Elderly Waiver
- Habilitation
- Health and Disability Waiver
- Intellectual Disability Waiver
- Physical Disability Waiver

### AIDS/HIV Waiver

The AIDS / HIV HCBS waiver pays for services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.

To be eligible, you must be:

- Diagnosed by a physician as having AIDS or HIV infection.
- Determined to need Nursing Facility (NF) level of care or hospital level care.

Based on your assessed needs, covered services may include:

### AIDS/HIV Waiver Services

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Counseling services
- Home-delivered meals
- Home health aide
- Homemaker services
- Nursing care
- Respite
- Consumer Choices Option (CCO)

### Brain Injury Waiver

The Brain Injury (BI) waiver pays for services for people with a brain injury diagnosis. The waiver allows them to return to the community from a medical institution.

To be eligible, you must be:

- Determined to have a brain injury diagnosis, as defined under the Iowa Administrative Code
- Determined to need Nursing Facility (NF), Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care
- At least 1 month of age

Based on your assessed needs, covered services may include:

## Brain Injury Waiver Services

- Adult day care
- Behavioral programming
- Consumer-Directed Attendant Care (CDAC)
- Family counseling and training
- Home and vehicle modifications
- Interim medical monitoring and treatment
- Personal Emergency Response System (PERS)
- Prevocational services
- Respite
- Specialized medical equipment
- Supported Community Living (SCL)
- Supported employment
- Transportation
- Consumer Choices Option (CCO)
- Medical Day Care for Children
- Enabling Technology for Remote Support

## Children's Mental Health Waiver

This waiver offers services for children up to age 18, who have been diagnosed with serious emotional disturbance.

To qualify, you must:

- Be aged from birth to age 18 years of age
- Have a diagnosis of serious emotional disturbance as verified by a licensed mental health professional within the past twelve months
- Be determined to need Psychiatric Medical Institution for Children (PMIC) level of care.

These services are managed by the Integrated Health Home Team

Based on your assessed needs, covered services may include:

## Children's Mental Health Waiver Services

- Environmental modifications and adaptive devices
- Family and community support services
- In-home family therapy
- Respite
- Medical Day Care for Children

## Elderly Waiver

The Elderly Waiver program provides assistance to qualified individuals who are 65 or older and prefer to stay in their own home or another community setting.

To qualify, you must be:

- 65 years of age or older
- Determined to need nursing facility level of care or skilled level of care

Based on your assessed needs, covered services may include:

## Elderly Waiver Services

- Adult day care
- Assistive devices
- Assisted living
- Chore services
- Consumer-Directed Attendant Care (CDAC)
- Emergency response system
- Home and vehicle modifications
- Home-delivered meals
- Home health aide
- Homemaker services
- Mental health outreach
- Nursing care
- Nutritional counseling
- Respite
- Senior companions
- Transportation
- Consumer Choices Option (CCO)

## Habilitation

Habilitation services are services for members who, because of their disability, need support and services that will help them learn, improve, and retain self-help, socialization and adaptive skills that are needed to live or work successfully in a community-based setting.

To qualify, you must:

- Be 16 years of age or older, have a serious mental illness or serious emotional disorder, with a functional impairment
- Be eligible for Medicaid and have a household income that does not exceed 150% of the Federal Poverty Level

- Meet a needs-based eligibility criteria as determined by a needs-based evaluation
- Meet one of two risk factors and meet at least two of five criteria showing a need for assistance for at least two years

Based on your assessed needs, covered services may include:

## Habilitation Services

- Case Management.
- Home-Based Habilitation - Individually tailored support that assists to develop or improve skills that you may need to live and/or work in the community.
- Day Habilitation- a Service that helps you with developing skills for participation in recreation, volunteerism, and integrated community employment, socialization, community participation and daily living skills.
- Prevocational Services, Career Exploration - Services that help you to develop employability skills and teach general employability skills relevant to participation in individual employment.
- Supported Employment –Ongoing supports designed to assist you with obtaining and maintaining an individual job that is competitive, customized or self-employment in an integrated work setting (which will offer you sustained paid employment) when you need support due to your disability.
- Enabling Technology for Remote Support

If you are interested in habilitation services, you need to apply for them. Your Molina case manager can assist you with this process to determine if you are eligible, and if you are, this will lead to the development or modification of your Person-Centered Service Plan to address your habilitation goals. This service can also be managed by an Integrated Health Home Team. For more information on Care Coordination through an Integrated Health Home please see the 'Health Home' section.

## Health and Disability Waiver

Health and Disability (HD) Waiver services may be available to people who:

- Are under age 65 and blind or determined disabled by receipt of Social Security disability benefits or through the Iowa Department of Human Services' disability decision process.
- Are ineligible for SSI if over age 21; members receiving HD Waiver services when reaching age 21 may continue to be eligible, regardless of SSI eligibility until they reach age 25.
- Meet all nonfinancial requirements for Medicaid.
- Are determined to need Nursing Facility (NF), Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care.

Based on your assessed needs, covered services may include:

### Health and Disability Waiver Services

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Counseling services
- Home and vehicle modifications
- Home-delivered meals
- Home health aide
- Homemaker services
- Interim medical monitoring and treatment
- Nursing services
- Nutritional counseling
- Personal Emergency Response System (PERS)
- Consumer Choices Option (CCO)
- Medical Day Care for Children

### Intellectual Disability Waiver

Intellectual Disability (ID) Waiver services may be available to people who:

- Have a diagnosis of intellectual disability as determined by a psychologist or
- psychiatrist
- Are determined to need Intermediate Care Facility level of care for the Intellectually
- Disabled (ICF/ID)

Based on your assessed needs, covered services may include:

### Intellectual Disability Waiver Services

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Day habilitation
- Home and vehicle modifications
- Home health aide
- Interim medical monitoring and treatment
- Nursing
- Personal Emergency Response System (PERS)
- Prevocational services
- Respite
- Supported Community Living (SCL)
- Residential Based Supported Community Living (RBSCL)

- Supported Employment
- Consumer Choices Option (CCO)
- Enabling Technology for Remote Support
- Medical Day Care for Children

Transportation: If you receive a daily Supported Community Living (SCL) under the Intellectual Disability (ID) Waiver, your transportation will be provided unless otherwise specified in your person-centered plan Consumer Choices Option (CCO).

## Physical Disability Waiver

The Physical Disability (PD) Waiver services may be available to people who:

- Have a physical disability
- Are ages 18 to 64. Are determined blind or disabled by receipt of Social Security disability benefits or through the Iowa Department of Human Services' disability determination process
- Meet Nursing Facility Level of Care or Skilled Nursing Facility Level of Care

## Physical Disability Waiver Services

- Consumer-Directed Attendant Care (CDAC)
- Home and vehicle modification
- Personal Emergency Response System (PERS)
- Specialized medical equipment
- Transportation
- Consumer Choices Option (CCO)

For more information about each of the HCBS programs please visit: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/hcbs**.

## Transportation for Waiver Services

If you are on a waiver that includes the transportation benefit, your case manager will:

- Work with you and your care team to determine the number of trips or mileage to be authorized.
- Submit the authorization to the appropriate parties to enable trips to be scheduled.
- Coordinate with you and your care team to arrange the waiver transportation up to 180 days in advance for recurring trips educate you and your care team on the ways in which to cancel scheduled waiver trips.

# Consumer Choices Option (CCO)

## Self-Direction

Self-Direction, also called Consumer Choices Option (CCO), means that you choose your personal caregiver(s). CCO is available under the Home and Community-Based Services (HCBS) waivers, with the exception of the Children's Mental Health (CMH) Waiver. CCO gives you control over a targeted amount of Medicaid dollars so that you can develop a plan to meet your needs by directly hiring employees and/or purchasing other goods and services. CCO offers more choice, control and flexibility over your services and also includes more responsibility. This will allow more direction and flexibility with your Home and Community-Based Services to enable you to stay in your home and community.

The CCO program allows you to have control over when your services are provided, how they are provided and who will be hired to provide your services to you. This gives you the ability to make choices, select and employ staff, and control the quality of your services. If you would like assistance to help manage your employees and/or budget, you can choose to delegate the tasks to someone else you trust to manage this for you. Your Community-Based Case Manager (CBCM) can work with you to delegate your budget authority.

**CCO may be right for you if you answer yes to these questions:**

- Do you want more control over how waiver Medicaid dollars are spent on your needs?
- Do you want to be the employer of the people that provide support to you?
- Do you want to be responsible for recruiting, hiring, and firing your workers and service providers?
- Do you want to be responsible for training, managing, and supervising your workers and service providers?
- Do you want the flexibility to be able to purchase goods or services in order to meet your needs?

If you would like to choose this option, you simply let your CBCM know you are interested. You will work with your Community-Based Case Manager to determine the services available for self-direction and develop a Person-Centered Service Plan (PCSP). You will choose an Independent Support Broker (ISB) who will help you develop your individual budget, organize your services, and help you recruit employees.

You will also work with a Financial Management Service that will help manage your tasks as an employer. They will complete background checks on your employees and will use your budget to pay your workers on your behalf.

You will be responsible for hiring and training your employees. Your caregivers must be able to pass a background check and be 18 years or older. You say how your care is given.

Your caregiver works for you. You will sign the timesheets and monitor how the services are provided. The caregiver may do things like help you with dressing, cleaning, fixing meals or other care needs identified in your assessment.

Your CBCM will complete a self-assessment tool with you to determine if you are eligible to self-direct your services. Please ask your Community-Based Case Manager (CBCM) for more details.

**The following Services can be chosen for self-direction:**

1. **AIDS/HIV Waiver**
    b. Consumer-Directed Attendant Care (CDAC)-Unskilled Services
    c. Home Delivered Meals
    d. Homemaker Services
    e. Basic Individual Respite
    f. Adult Day Care
2. **Brain Injury Waiver**
    a. Consumer-Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Prevocational Services
    d. Basic Individual Respite
    e. Specialized Medical Equipment
    f. Supported Community Living
    g. Supported Employment
    h. Transportation
    i. Medical Day Care for Children
    j. Adult Day Care
3. **Elderly Waiver**
    a. Assistive Devices
    b. Chore Services
    c. Consumer-Directed Attendant Care (CDAC)-Unskilled Services
    d. Home and Vehicle Modification
    e. Home Delivered Meals
    f. Homemaker Services
    g. Basic Individual Respite
    h. Senior Companion
    i. Transportation
    j. Adult Day Care

4. **4. Health and Disability Waiver**
    a. Consumer-Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Home Delivered Meals
    d. Basic Individual Respite
    e. Homemaker
    f. Medical Day Care for Children
    g. Adult Day Care
5. **Intellectual Disability Waiver**
    a. Consumer-Directed Attendant Care (CDAC)-Unskilled Services
    b. Day Habilitation
    c. Home and Vehicle Modification
    d. Prevocational Services
    e. Basic Individual Respite
    f. Supported Community Living
    g. Supported Employment
    h. Transportation
    i. Medical Day Care for Children
    j. Adult Day Care
6. **Physical Disability Waiver**
    a. Consumer-Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Specialized Medical Equipment
    d. Transportation

Please note that some services may need to use Electronic Visit Verification (EVV), a tracking system that proves when a person receives a Medicaid-funded personal care service. Currently, this is used for Consumer-Directed Attendant Care (CDAC) and Homemaker services. For questions regarding EVV services or your role as a member in them, please contact your assigned Community-Based Case Manager (CBCM).

If you feel the CCO is right for you, talk with your CBCM to learn more.
You may choose to stop directing your own care at any time. Just talk with your CBCM for help on the process to stop self-directing your services. More information about the CCO is online at: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs**.

# Consumer Directed Attendant Care

Medicaid Home- and Community-Based Services (HCBS) Waiver programs offer the opportunity for you to have help in your own home or your community. One option is Consumer Directed Attendant Care, or CDAC, which can give you the help you need to stay in your own home. CDAC services must be direct, hands-on services. CDAC services cannot provide for your personal supervision or for someone to stay with you overnight.

There are two kinds of CDAC services, unskilled and skilled.

**Unskilled services** include help with normal daily life activities such as dressing, bathing, meals, bedtime, taking medicine, making appointments, handling money, communicating with others, doctor visits, errands, and housekeeping.

**Skilled services** are medical services that require a licensed nurse or therapist to supervise the person who does these things for you. These include monitoring medications, post-surgical nursing care, injections, recording vital signs, tube feedings, catheter care, colostomy care, therapeutic diets and intravenous therapy.

**You are the employer of your CDAC.** You will need to make an employee agreement outlining the duties your CDAC provider will perform. Your CDAC provider can be a person that you know or someone from an agency. Remember, this person will be in your home helping you do things needed to keep you in your home. It is important that you feel comfortable with him or her. Your Community-Based Case Manager (CBCM) can help you determine how much funding is available to you under your HCBS Waiver for CDAC services. This will help you plan work schedules and provider salaries.

**Electronic Visit Verification (EVV).** CDAC services are required to be confirmed through EVV unless you live in an Assisted Living or Residential Care Facility. For all other agency or individual CDAC providers, this is a requirement. This verification should be done by your provider on the date of service to help ensure timely payment. For questions regarding this process or your role in EVV, please contact your assigned Community-Based Case Manager (CBCM).

**How to get CDAC services**

To receive CDAC, you must already be receiving HCBS waiver services. If you request CDAC as a service, you will have a meeting with your CBCM and other people you want to include. Your CBCM must agree that CDAC services are right for you so that you are healthy and safe.

For more information on finding the right provider, work contracts, salaries, recordkeeping, backup plans, personnel issues, reporting abuse and more, visit hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/cdac.

# Health Home Program

A Health Home is an approach to care coordination for individuals with multiple chronic conditions, including mental health and substance use disorders. The health home provides a team-based clinical approach that includes the member, their medical providers, and family members (when appropriate). The Health Home model builds on community supports and resources and enhances coordination and integration of primary and behavioral healthcare to better meet the needs of members with multiple chronic illnesses.

Molina offers a Health Home program to support you and your health by integrating and coordinating the care and services you receive. Your health home will oversee all your healthcare needs and make sure you get the best care available to you.

**These services include:**

- Someone to help you develop a health action plan to guide you and your doctors
- and other providers
- Someone to meet with you to help you get the right services at the right time
- Help with learning about your conditions and how you can help yourself be healthier
- Help when coming out of the hospital to make sure you can get important follow-up
- visits to doctors and other providers
- Help with understanding how your family or other helpers support you in reaching
- your health goals
- Help getting other services and support you need to stay in your home

**Integrated Health Home**
An Integrated Health Home (IHH) is a team of professionals, including family and peer support services, working together to provide members with whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). This includes individuals currently receiving Targeted Case Management (TCM) and Case Management through Medicaid-funded Habilitation or a HCBS Waiver Program. Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience. The IHH will assist members with their paperwork and guide them through the application process for benefits for which they qualify. The IHH will coordinate all services for an individual, including medical, behavioral, and community services regardless of the funding sources for those services.

**IHH** is an optional program of member choice. Members are eligible for Integrated Health Homes (IHH) services if they have been diagnosed with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) and have a functional impairment assessment completed by a Licensed Mental Health Professional.

**SMI** is defined as an adult that has a persistent or chronic mental health, behavioral, or emotional disorder specified within the most current Diagnostic and Statistical Manual (DSM)

of Mental Disorders published by the American Psychiatric Association or its impairment and substantially interferes with or limits one or more life activities, including functioning in a family, school, employment, or community.

**SED** is defined as a child with a diagnosable mental, behavioral, or emotional disorder specified within the most current Diagnostic and Statistical Manual (DSM) of mental disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that results in functional impairment that substantially interferes with or limits the child's role of functioning in family, school, or community activities.

To be eligible for Integrated Health Home (IHH) services, you must have one of the following clinical conditions:

- An adult with a serious mental illness (SMI): psychiatric disorder, schizophrenia,
- schizoaffective disorder, major depression, delusional disorder, obsessive-compulsive disorder, or bipolar disorder; or
- A child or youth with a serious emotional disturbance (SED): a diagnosable mental,
- behavioral, or emotional disorder that impairs function.

Members who are enrolled in the Habilitation and Children's Mental Health Waiver are also enrolled in an IHH.

SMI and SED may co-occur with substance use disorder, developmental, neurodevelopmental, or intellectual disability but those diagnoses may not be the clinical focus for health home services.

Being in the Health Home program is your choice. You can choose to be in a Health Home program, change your Health Home or leave the program at any time.

## If you wish to change your Health Home, you can:

- Request this change through your current Health Home or through the Health Home in which you would like to transfer or Call Molina for help at **(844)-236-0894 (TTY 711)**.

Changing your Health Home will not change your benefits, as long as you are eligible for the program.

**Health Home program services are extra support to help you meet your health goals.**
If you have questions about the Health Home program or to see if you are eligible for a Health Home, call Member Services at (**844) 236-0894 (TTY 711)**.

For additional information on eligibility, participation or making changes to a currently assigned Integrated Health Home programs, please talk with your Community-Based Case Manager (CBCM), Care Coordinator or local Integrated Health Home to learn more.

# Your Rights and Responsibilities

As a Molina member, you have certain rights. You also have responsibilities. They are listed below.

**Your rights:**

- To be treated with respect, dignity, and privacy
- To receive information about Molina Healthcare, our services, and providers in a manner that you can understand
- To fully participate in the community and work, live and learn to the fullest extent possible
- To be sure that your medical record information is kept private
- To say no to treatment or therapy. If you say no, the provider or Molina Healthcare must talk to you about what could happen, and they must put a note in your medical record about it
- To be given information about your health. This information may also be available to someone who you have legally approved to have this information or who you have said should reached in an emergency when it is not in the best interest of your health to give it to you
- To discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage
- To participate with providers in making decisions relating your health care
- To be able to take part in decisions about your health care, including the right to refuse treatment
- To get information on any medical care treatment, given in a way that you can understand
- To be sure others cannot hear or see you when you are getting medical care
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed
- To file an appeal, a grievance (complaint) or state hearing. See the Grievance and Appeals section of this handbook to learn more.
- To be able to choose primary care practitioners, including specialists as your PCP if you have a chronic condition, within the limits of the plan network, including the right to refuse care from specific practitioners
- To change your primary care provider (PCP) to another PCP in the Molina Healthcare's network. Molina Healthcare must send you something in writing that says who the new PCP is by the date of the change
- To be told if the health care provider is a student and to be able to refuse their care
- To be told of any experimental care and to be able to refuse to be part of the care

- To be free to carry out your rights and know that the Molina Healthcare providers, or the Iowa HHS will not hold this against you
- To get a second opinion from a qualified provider in Molina Healthcare's network. If a qualified provider is not able to see you, Molina Healthcare must set up a visit with a provider not in our network
- To make advance directives (a living will). See the 'Making a Living Will' section to learn more about advance directives
- To know that Molina Healthcare must follow all federal and state laws, and other laws about privacy that apply
- To get help with care coordination from the PCP's office
- To choose your healthcare professional and LTSS Providers to the extent possible and appropriate
- To be given access to healthcare services in a timely manner, including services available 24 hours a day, 7 days a week when medically necessary
- To get healthcare services that are similar in amount and scope to those given under Medicaid FFS, which includes the right to get healthcare services that will achieve the purpose for which the services are provided
- To get services that are fitting and are not denied or reduced due to diagnosis, type of illness, or medical condition

- To get help free of charge from Molina Healthcare and its providers if you do not speak English or need help in understanding information
- To get all written member information from Molina Healthcare:
  - at no cost to you
  - in the prevalent non-English languages of members in the Molina Healthcare service area
  - in other ways, to help the special needs of members who may have trouble reading the information for any reason
- To get help with sign language if you are hearing impaired
- To get adequate and timely information on Molina's Physician Incentive Plan upon request
- To submit an exception request for consideration by Iowa HHS for items or services not covered
- To get information about Molina Healthcare from us
- You also have the right to:
  - Voice complaints about Molina Healthcare
  - Voice complaints about the care you were given
  - Request appeals for denied prior approval requests
  - Get information about Molina Healthcare
  - Get information about covered benefits
  - Get information about network providers
  - Openly discuss your treatment options in a way that is easy to understand. You have this right no matter the cost or benefit coverage
  - Get information about your rights and responsibilities
  - Make suggestions about Molina Healthcare's members' rights and responsibilities

## Your responsibilities:

- Show your Medicaid card each time you visit your healthcare provider and make sure their office has a record that you are on Medicaid.
- Confirm that your provider is enrolled with Medicaid. If the provider writing your prescription or providing your care is not a Medicaid provider, Medicaid will not pay for it. Medicaid will not pay for services from a provider who is not enrolled with Medicaid.
- If you can, find out before you ask for a new or special type of treatment if it requires prior approval from Iowa Medicaid. If it does and the approval is not received, you could become responsible for payment.
- Keep all scheduled appointments - or call to cancel or reschedule. Some providers may stop seeing you if you miss one or more scheduled appointments.
- Share health information (to the extent possible) with Molina Healthcare and your providers. Do this so that you get the right care.
- Understand your health conditions (to the degree possible). Be active in decisions about your healthcare.

- Work with your provider to develop treatment goals. Follow the care plan that you and your provider have developed.
- Make sure you take the medications prescribed by your doctor.
- During office appointments, review your medications to keep the list current.
- Ask questions if you do not understand your benefits.
- Tell Molina Healthcare if you would like to change your primary care provider (PCP). Molina Healthcare will make sure the PCP you pick is in our network and taking new patients.
- Tell Molina Healthcare if you change your name, address or telephone number.
- Seek medical services that are medically necessary. HHS may limit your services if you use Medicaid for services that are not necessary.
- Tell Molina Healthcare if you have any changes that could affect your Medicaid eligibility.
- Tell Molina Healthcare and your health care providers if you or any of the members of your family have other health insurance coverage.
- Tell Iowa Medicaid Member Services about any changes to other health insurance coverage. Tell them if coverage ends, you lose or get new coverage or change insurance companies. Call Member Iowa Medicaid Member Services toll-free at **(800) 338-8366**.
- Tell your medical providers about anyone else who may be legally responsible to pay your medical bills.
- Treat your Medicaid number the way you treat your Social Security number—do not loan or sell it to anyone.
- Keep your Medicaid card in a safe place, the way you protect your money or checkbook—out of sight of everyone.
- If you suspect that someone is misusing their Medicaid benefits or someone who is not your provider requests your Medicaid information, please call The U.S. Department of Health & Human Services at **(800) 447-8477** or call Member Services at (800) 338-8366 or locally (Des Moines area) at **(515) 256-4606**.

# Other Insurance and Bills

## If you have Medicare

If you have both Medicare and Medicaid coverage, your Medicare or Medicare HMO coverage is considered your primary insurance. Your Medicaid coverage through Molina is secondary. Medicare will cover services from participating physicians, hospitals and other network providers.

Medical services are based on the guidelines of your Medicare program. Your doctor will bill Medicare first for services covered by both programs and Medicaid will be billed second for any cost sharing.

Your Medicaid benefits will not affect your primary insurance benefits.

Be sure to show both your Medicare and Medicaid ID cards each time you go to a doctor's visit.

If you have any questions about your coverage, please call Molina Member Services at **(844) 236-0894 (TTY: 711).**

### Help with Employer Provided Insurance Premiums

The Health Insurance Premium Payment (HIPP) program is a service available to people who get Medicaid. The HIPP program helps people get or keep health insurance through their employer by reimbursing the cost of the health insurance premium.

To complete an application by phone or for questions, call (**888) 346-9562**. For a paper application, please visit **hhsstate.ia.us/hipp**. Applications may be returned by fax at **(515) 725-0725** or email at **hipp@hhs.state.ia.us**.

### Veteran Benefits

The Iowa Department of Veteran Affairs (IDVA) staff includes benefits specialists, accredited by the U.S. Department of Veterans Affairs, who specialize in federal VA benefits, as well as state benefits. They advise veterans and family members of veterans concerning federal VA benefits they may be entitled to receive. These include pension, disability compensation, and other ancillary benefits. Benefit specialists can also represent claimants with federal claims and review all correspondence pursuant to those claims to determine if an award action or denial was correct. For additional information, please call the IDVA office at **(515) 252-4698** or **(800) 838-4692** and ask for a benefit specialist.

# Grievances and Appeals

## Grievances

We hope you are happy with the care and services you receive. If you are not, we want you to know you have options. You, or someone you choose to help you may file an appeal or grievance by phone or in writing. Molina can help you complete forms to file a grievance or an appeal free of charge. If you need help, please call Member Services at our toll-free number **(844) 236-0894 (TTY: 711)**. We have people to help you Monday through Friday, 7:30 a.m. - 6:00 p.m. CST. Translation services are also available if needed. Molina will not treat you differently for filing an appeal or grievance.

- A grievance is a compliant, other than an "Adverse Benefit Determination", about the way your health care services were handled by your provider or Molina.  Some examples are:
- Rudeness from a provider or employee.
- The quality of your care or how you were treated.
- Failing to respect your member rights.
- You are unhappy with the time it takes for authorization decisions.
- You disagree with the decision to extend an appeal timeframe.
- You want to request a disenrollment from Molina Healthcare of Iowa.
- Any other problems you may have getting health care.

## How to file a grievance

You may file a grievance with Molina at any time. You may choose someone to help you file a grievance; this is called an authorized representative. You must give written consent to allow someone to file a grievance on your behalf.

- You can call Member Services toll free at **(844) 236-0894 (TTY 711)**.
- You may mail it to:
- Molina Healthcare of Iowa
- P.O. Box 93010
- Des Moines, IA 50393
- Send by fax: **(888) 832-1922**
- or send by email to: **lowamemberappealsgrievances@molinahealthcare.com**

## What to expect when you file a grievance

You will not be treated differently for filing a grievance. When we get your grievance, we will send you a letter within 3 business days letting you know that we got it. We will let you know in writing our decision about your grievance within 30 calendar days from the day we got your grievance. If we need additional time to make our decision, a 14 calendar-day extension may be requested. If additional time is needed, we will let you know by phone or in writing within 2 days explaining why it is in your best interest. You may also request an extension if you need more time to support your grievance.

If your grievance is due to an urgent or emergent issue, we will let you know our decision within 72 hours from when we receive your grievance. Molina may take a 14 calendar-day extension if we feel it is in your best interest. If additional time is needed, we will let you know by phone or in writing within 2 days explaining why it is in your best interest. You may also ask for an extension if you need more time to gather additional information.

## Appeals

You may request an appeal for Molina to review a decision that we made about a service that was denied, reduced, or limited. Some examples of appeals would be:

- Denial in whole or part of a requested service
- Stop a service that was previously approved.

A denial is when we do not approve or pay for a service that either you or your doctor asked for. When we deny a service, we will send you a letter telling you why we denied the requested service. This letter is the official notice of our decision and is called an "Adverse Benefit Determination." It will let you know your rights and information about how to request an appeal.

## How to file an appeal

You must send your appeal within **60** calendar days of the date of Molina's denial letter.

You, your approved representative, or provider on your behalf and with your written consent can appeal the decision. If you need help filing your appeal, you can call Molina Member Services and we will help you complete the steps for filing an appeal.

You can appeal our decision in writing or over the phone by calling Member Services at **(844) 236-0894 (TTY 711)**.

- By mail at:
- Molina Healthcare of Iowa
- P.O. Box 93010
- Des Moines, IA 50393
- By fax: 1-888-832-1922
- Or, by email: **Iowamemberappealsgrievances@molinahealthcare.com**

An appeal form and authorized representative form can be found in your denial letter and online at **MolinaHealthcare.com**. Molina offers only one (1) level of appeal for members.

## What to expect when you file an appeal

You will not be treated differently for filing an appeal. You will receive a letter within 3 business days letting you know that we received your appeal. You will be notified of our decision within 30 calendar days for a standard appeal. We may request an extension of 14 calendar days if we feel it is in your best interest. We will send you a letter within two (2) days of you notifying us of the need for the extension, if you disagree with our decision to extend your appeal, you have the right to file a grievance.

If waiting 30 days will harm your health or life, you can ask for a fast (expedited) appeal. We will make a decision within 72 hours or sooner. If the request does not need to be completed in 72 hours, we will notify you in writing and will complete your appeal in the standard 30 days.

If Molina fails to resolve your appeal and provide notice within the required timeframe above, then your appeal with Molina is considered to be exhausted and you may request a State Fair Hearing.

## State Fair Hearings

If you are unhappy with our decision of your appeal, you can ask for a State Fair Hearing. You must first complete your appeal with Molina before you ask for a State Fair Hearing. You, your authorized representative, or your doctor on your behalf with your written consent can request the State Fair Hearing. You must send your request within 120 calendar days from the date on the letter from Molina notifying you of our decision.

You can make a request to the Iowa Department of Health and Human Services for a State Fair Hearing in writing, in person or by phone. If you need help with your appeal or want to file by phone

you can call the Iowa Department of Health and Human Services (HHS) office by contacting the HHS Appeals Section at **(515) 281-3094**.

To file in writing, please send requests to:

Department of Health and Human Services Appeals Section
1305 E. Walnut, 5th Floor
Des Moines, IA 50319-0014

### Continuing Services during an Appeal or State Fair Hearing

Molina will continue your benefits when an appeal or State Fair Hearing is pending, if all of the following are met:

- You must file the request for an appeal within 60 calendar days for the notice from Molina denying your service request.
- The appeal or State Fair Hearing request is related to the termination, suspension or reduction of services that were previously authorized for you.
- The services were requested by an authorized Molina doctor.
- The period covered by the original authorization has not ended.
- The request for continuation of benefits is filed:
    - Within in 10 calendar days from the date we mailed the Adverse Benefit Determination or
    - By the effective date of the notice.

If the above are met, your benefits must be continued until one of the following occurs:

- You ask to stop the appeal or State Fair Hearing.
- You do not request a State Fair Hearing within 10 days from the date of Molina's letter notifying you of our decision.
- The authorization for services expires, or service authorization limits are met.
- A State Fair Hearing decision is to deny your request.

**Note**: IF you keep getting a service during the appeal process or State Fair Hearing and you lose the appeal, **you may have to pay for the services you received**.

## Ombudsman

### Iowa Managed Care Ombudsman Program

You can call Member Services for help, however, if you still need help and you get long-term care in a facility or home-and community-based services waivers, independent advocacy services are available to help you with:

- Education and Information
- Problems you cannot resolve by calling Molina Member Services

- Filing a grievance, an appeal, or State Fair Hearing request
- If you feel your rights are not respected
- If you feel you are not getting the care you need

You may contact the Managed Care Ombudsman by mail, phone, fax or email at:

Office of the State Long-Term Care Ombudsman
Attn: Managed Care Ombudsman
Jessie M. Parker Building
510 E 12th Street, Suite 2
Des Moines, IA 50313-9025
Phone: **(515) 725-3333** or toll free at **(866) 236-1430**
Fax: 515-725-3313
Email: **managedcareombudsman@iowa.gov**

If you are a member who is not receiving the long-term care services the Managed Care Ombudsman covers, you may contact the State of Iowa Ombudsman Office for assistance by mail, phone, fax or email at:

State of Iowa, Ombudsman Office
Ola Babcock Miller Building
1112 E Grand Avenue
Des Moines, IA 50319
Phone: **(515) 281-3592** or toll free at **(888) 426-6283**
Fax: **(515) 242-6007**
Email: **ombudsman@legis.iowa.gov**

# Estate Recovery

The cost of medical assistance is subject to recovery. The state of Iowa has the right to ask for money back from your estate after your death. Estate recovery may include the full amount of capitation payments made to a managed care plan, including medical and dental, even if the plan did not pay for any services. Members affected by the estate recovery policy are those who:

- Are 55 years of age or older, regardless of where they are living; or
- Are under age 55 and:
  - Reside in a nursing facility, an intermediate care facility for persons with an intellectually disability, or a mental health institute, and
  - Cannot reasonably be expected to be discharged and return home.

For more information, call Iowa Medicaid Member Services at **(800) 338-836**6 or **(515) 256-4606** (when calling within the Des Moines area) **(TTY: 1-800-735-2942)** Monday through Friday from 8 a.m. to 5 p.m. or access the Iowa Medicaid website at

hhs.iowa.gov/programs/welcome-iowa-medicaid/member-services/estate-recovery
or visit hhs.iowa.gov and enter estate recovery in the search bar.

For more information about Iowa's estate recovery rules, see Iowa Administrative Code: 441 IAC 75.28(7).

# Making a Living Will

All Molina adult members have a right to make Advance Directives. An Advance Directive protects your rights for medical care. It helps to plan for future treatment decisions ahead of time. It tells people what you want if you would not be able to make your own decisions. Your doctor can help discuss these options before you have an emergency. Then if you do have a medical emergency and cannot communicate what you need, your doctors will already know what to do.

### Examples of common types of Advance Directives include:

**A Living Will or declaration.** A living will tells your health care providers and family about the type of life-sustaining actions you want, and do not want, if you suffer from a terminal illness or an irreversible condition. A living will does not apply unless you cannot make decisions for yourself; until then, you will be able to say what treatments you want or do not want. A living will is only used when you are near the end of life with no hope to recover.

**Treatments could include:**

- Feeding tubes
- Breathing machines
- Organ transplants
- Treatments to make you comfortable

**If you wish to sign a living will, you can:**

- Ask your primary care provider (PCP) for a living will form.
- Fill out the form by yourself or call Molina for help.
- Take or mail the completed form to your PCP or specialist. Your PCP or specialist will then know what kind of care you want to get.

**A Durable Healthcare Power of Attorney.** This names someone who is allowed to make healthcare decisions for you when you cannot make them yourself.

**A "Do Not Resuscitate" (DNR) Order.** This tells healthcare providers not to give Cardiopulmonary Resuscitation (CPR) if your heart and/or breathing stops. A DNR order is only about CPR. It does not provide instructions about other treatments.

# Fraud, Waste and Abuse

Molina is committed to preventing, identifying and reporting all instances of suspected fraud, waste and abuse. Fraud, waste and abuse means that any member, any provider, or another person is misusing the Iowa Medicaid program or Molina resources.

### Fraud:

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

### Waste:

Health care spending that we can eliminate without reducing the quality of care.

### Abuse:

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

Our Fraud, Waste and Abuse Plan helps Molina, its employees, members, providers, payers and regulators. The plan helps by increasing efficiency, reducing waste and improving the quality of services.

- We take the prevention, detection and investigation of fraud, waste and abuse seriously.
- We comply with state and federal laws.
- We investigate all suspected cases of fraud, waste and abuse. We promptly report them to government agencies when needed.
- We take the appropriate disciplinary action. This may include termination of employment, provider status and/or membership.

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

To report suspected Medicaid fraud or abuse, call the Molina Healthcare Alert Line at **(866) 606-3889 (TTY:711)** or complete a report form online at **MolinaHealthcare.alertline.com**.

### Here are some ways you can help stop fraud:

Do not give your Molina member ID card, Medical ID Card or ID number to anyone else. Only give them to a health care provider, a clinic or hospital when getting care.

- Never let anyone borrow your Molina member ID Card.
- Never sign a blank insurance form.
- Be careful about giving out your social security number.

# Notice of Privacy Practices

Your privacy is important to us. We respect and protect your privacy.

**Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.**

Information about your health and income is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you are a member right now or if you used to be, your information is safe.

We get information about you from state agencies for IA Health Link and Hawki after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Protected Health Information (PHI) is health information that may be used or shared by us. This may include:

- Name
- Member ID number
- Race
- Ethnicity
- Social needs
- Language
- Gender
- Gender identity
- Sexual orientation

We use and share your information to provide you with health benefits. We want to let you know how your information is used or shared.

We may use or share your PHI to:

- Give you treatment
- Pay for your health care
- Review the quality of the care you get
- Tell you about your choices for care
- Run our health plan
- Share PHI 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 given your PHI

## 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.

We will be happy to answer your questions as a member of Molina. You may call our Member Services Department Toll-Free at **(844) 236-0894 (TTY: 711)**.

# Other Plan Details

## Our Quality Improvement Plan and Program

**We are committed to making sure you get the best care possible. That is why we put a plan in place every year to keep improving:**

- Our services
- The quality of care you receive
- The way we communicate with you

Our goals are to:

- Give you services that benefit your health
- Work with providers to get you the care you need
- Address your language and cultural needs
- Reduce any barriers to getting care

We also want to hear how we are doing. We review the past year of service to check our progress. We may send you a member survey to get your feedback.

We may also send surveys to see how many members get the services needed. These surveys tell us what care is needed. One of these surveys is the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey.

### This survey asks questions about how you rate:

- Your health care
- Your primary care provider (PCP)
- Your health plan
- Specialist(s) you have seen
- Well-check exams
- How easy it is for you to get care
- How easy it is for you get care quickly

### HEDIS (Healthcare Effectiveness Data and Information Set)

We also measure how many of our members get key tests and exams. We look at:

- Annual exams
- Diabetes care
- Mammograms (x-rays of the breast)
- Medicine management
- Pap tests
- Prenatal care

- Postpartum care
- Shots (flu, child and teen shots)

**We care about your health. We want you to help take better care of yourself and family. To do this, we:**

- Remind you to get well-check exams and shots
- Teach you about chronic health problems that you may have
- Make sure you get prenatal and postpartum care if you are pregnant
- Remind you to get Pap tests and mammograms, if needed
- Address any complaints you have
- Help you find and use information on our website
- Tell you about special services we offer

To learn more, call Member Services at **(844) 236-0894 (TTI: 711)** Monday through Friday, 7:30 am-6:00 pm. You can ask for a printed copy of our Quality Improvement plan and results.

### Guidelines to keep you healthy

We give you information about preventive services and when to get them. The information does not replace your doctor's advice.

**To make the most of these guidelines:**

- Take time to read them
- Write down questions and bring them to your next checkup
- Tell your provider about any health problems you or your children are having
- Go to your appointments
- If you miss an appointment, reschedule right away
- We tell you about key tests and exams for issues like diabetes, COPD and depression

We share guidelines to help you learn about ways to stay healthy and learn about health conditions, such as diabetes, COPD, and depression. See **MolinaHealthcare.com/IA** for details. To learn more, call Member Services at **(844) 236-0894 (TTI: 711)** Monday through Friday, 7:30am-6:00pm. **MolinaHealthcare.com**.

## How to Disenroll from Molina Healthcare of Iowa

You have the right to request disenrollment from Molina Healthcare of Iowa. Each request is either without cause or for good cause. You can request disenrollment without cause at the following times:

- 90 days following your initial enrollment with Molina Healthcare of Iowa or 90 days following the date you receive the notice of enrollment sent by the State of Iowa, whichever date is later

- Once every 12 months thereafter
- You are automatically enrolled if you had a temporary loss of Medicaid enrollment that caused you to miss the annual disenrollment opportunity, or
- If Molina Healthcare of Iowa is notified by the State of Iowa of a violation that results in a suspension of new enrollment

A request for disenrollment for good cause can be made at any time. One or more of the following reasons must be true in order for a disenrollment request to be considered for good cause:

- You move out of the MCO's service area
- Molina Healthcare of Iowa does not cover a service you need due to moral or religious objections
- You need services where there is not a provider in Molina Healthcare of Iowa's provider network, or you are subject to unnecessary risk by using another provider
- For members using Managed Long-Term Services and Supports (MLTSS), you have to change your residential, institutional or employment supports provider based on that provider not included in Molina Healthcare of Iowa's provider network and would cause you to experience a disruption in your residence or employment, or
- You are receiving poor quality of care, lack of access to covered services that are needed, or lack of access to providers experienced in dealing with your care needs

You must file a Grievance (please refer to the Grievance section of this manual for further instructions on how to file a Grievance) with Molina Healthcare of Iowa before the State of Iowa will allow you to request disenrollment for good cause. Once Molina Healthcare of Iowa renders a decision, Molina notifies HHS of our decision. HHS will make the final determination upon your request to HHS after Molina's decision has been made.

*Molina may request disenrollment of a member in the rare instance that a member's continued enrollment seriously impairs Molinas' ability to furnish services to the member or other members.*

# Glossary of Terms

**Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

**Appeal:** An appeal is a request for a review of an action. A member or member's authorized representative may request an appeal following a decision made by Molina.

Molina actions that a member may choose to appeal:

- Denial of or limits on a service
- Reduction or termination of a service that had been authorized
- Denial in whole or in part of payment for a service

- Failure to provide services in a timely manner
- Failure of Molina to act within required timeframes
- For a resident of a rural area with only one MCO, the denial of services
- outside the network
- Members may file an appeal directly with Molina. If the member is not happy with the outcome of the appeal, they may file an appeal with the Department of Health and Human Services (HHS). Or they may ask for a state fair hearing.

**Care Management:** Care Management helps you manage your complex health care needs. It may include helping you get other social services, too.

**Chronic Condition:** Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

**Chronic Condition Health Home:** Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

**Client Participation:** Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing home or home supports.

**Community-Based Case Management (CBCM):** Community-Based Case Management helps Long-Term Services and Supports (LTSS) members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost-effective outcomes. Community-Based Case Managers (CBCMs) make sure that the member's care plan is carried out. They make updates to the care plan as needed.

**Consumer Directed Attendant Care (CDAC):** Consumer Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.

CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

**Co-payment (Copay):** Some medical services have a co-payment, which is your share of the cost. If there is a co-payment, you will pay it to the provider. The provider will tell you how much it is.

**Durable Medical Equipment:** Durable medical equipment. DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home.

**Emergency Medical Condition:** An Emergency Medical Condition is any condition that you believe endangers your life or would cause permanent disability if not treated immediately.

If you have a serious or disabling emergency, you do not need to call your provider or Molina. Go directly to the nearest hospital emergency room or call an ambulance.

The following are examples of emergencies:

- A Serious accident
- Stroke
- Severe shortness of breath
- Poisoning
- Severe bleeding
- Heart attack
- Severe burns

**Emergency Medical Transportation:** Ambulance services for an emergency medical condition.

**Emergency Room Care:** Emergency services that a member receives in an emergency room.

**Emergency Services:** Emergency Services are provided when you have an Emergency Medical Condition.

**Excluded Services:** Services that are not covered on the members identified plan.

**Good Cause:** You may request to change your MCO during your 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.

Some examples of Good Cause for disenrollment include:

- You move out of the MCO's service area
- Your provider is not in the MCO's network
- You need related services to be performed at the same time. Not all related services are available within your MCO's provider network. Your primary care provider or another provider determined that receiving the services separately would subject you to unnecessary risk
- Lack of access to providers experienced in dealing with your health care needs
- Your provider has been terminated or no longer participates with your MCO
- Lack of access to services covered under the contract
- Poor quality of care given by your MCO
- The MCO plan does not cover the services you need due to moral or religious objections
- You use Long Term Support Services (LTSS) and would experience a disruption in where you live or your employment due having to change providers based on a provider becoming out of network with the MCO.

**Grievance:** You have the right to file a grievance with Molina. A grievance is an expression of dissatisfaction about any matter other than a decision. You, your representative or provider who is acting on your behalf and has your written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred.

Examples include, but are not limited to:

- You are unhappy with the quality of your care
- The doctor who you want to see is not a Molina doctor
- You are not able to receive culturally competent care
- You got a bill from a provider for a service that should be covered by Molina Healthcare of Iowa
- Rights and dignity
- You are commended changes in policies and services
- Any other access to care issues

**Habilitation Services:** Habilitation Services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities.

**Health Care Coordinator:** A Health Care Coordinator is a person who helps manage the health of members with chronic health conditions.

**Health Insurance:** A type of insurance coverage that pays for medical and surgical expenses incurred by the insured.

**Health Risk Assessment:** A Health Risk Assessment (HRA) is a short survey with questions about your health.

**Healthy Behaviors Program:** Members in the Iowa Health and Wellness Plan can get free* healthcare if they complete what are known as Healthy Behaviors. To participate in the Healthy Behaviors program and avoid monthly payments after the first year, each year Iowa Health and Wellness Plan members must:

1. Get a Wellness Exam

AND

2. Get a Health Risk Assessment

*There are very few, or no, costs for the first year and very few costs after that. A small monthly payment may be required based on income. There is an $8 copay for using the emergency room for non-emergency services.

**Home and Community-Based Services (HCBS):** Home-and Community-Based Services (HCBS) provide supports to keep Long Term Services and Supports (LTSS) members in their homes and communities.

**Home Health:** Home health care is a wide range of health care services that can be given in a member's home for an illness or an injury.
Hospice: Services to provide comfort and support for members in the last stages of a terminal illness, and their families.

**Hospitalization:** Inpatient care based on diagnosis-related groups.

**Hospital Outpatient Care:** Care in a hospital that usually doesn't require an overnight stay.

**Integrated Health Home:** An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

**Level of Care:** Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by HHS.

**Long-Term Services and Supports (LTSS):** Long Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.

**Long-Term Care Services:**

- Home- and Community-Based Services (HCBS)
- Intermediate Care Facilities for Persons with Intellectual Disabilities
- Nursing Facilities and Skilled Nursing Facilities

**Medically Necessary:** Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

**Network:** Molina has a network of providers across Iowa who you may see for care. You do not need to call us before seeing one of these providers. Before getting services from your providers, please show them your Molina ID card to ensure they are in our network. There may be times when you need to get services outside of our network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to you than if provided in-network.

**Non-participating provider:** A provider that is enrolled with Iowa Medicaid, is credentialed, but not contracted, with a managed care plan.

**Over-the-Counter Medications (OTC):** Molina covers many over-the-counter (OTC) medications that are on the state's approved list. A provider must write you a prescription for the OTC medication you need.

**Participating Provider:** A provider that is enrolled with Iowa Medicaid and is credentialed and contracted with a managed care plan.

**Person-centered Plan:** A Person-centered Plan is a written individual plan based on your needs, goals, and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP) or individual education plan (IEP).

**Physician Services:** Health care services a licensed medical physician provides or coordinates

**Plan:** An individual or group plan that provides, or pays the cost of, medical care.

**Premium:** A health insurance premium is the amount that policyholders pay for health coverage.

**Prescription Drug Coverage:** Health insurance or plan that helps pay for prescription drugs and medications.

**Prescription Drugs:** Prescription Drugs are drugs that, by law, require a prescription.
Prevocational Services: Prevocational Services are services where the member can gain skills that lead to paid employment.

**Primary Care Physician:** A Primary Care Physician directly provides or coordinates your health care services. A Primary Care Physician is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

**Primary Care Provider:** A Primary Care Provider (PCP) is either a physician, a physician assistant or nurse practitioner, who directly provides or coordinates your health care services. A PCP is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

**Prior-Authorization (or Preauthorization):** Some services or prescriptions require approval from Molina for them to be covered. This must be done before you get that service or fill that prescription.

**Provider:** A Provider is a health care professional who offers medical services and support.

**Rehabilitation Services and Devices:** Rehabilitation Services and Devices help you keep, get back, or improve skills for daily living after you were sick, hurt, or disabled. This may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation.

**Serious Emotional Disturbance (SED):** Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.
SED does not include:

- Neurodevelopmental disorders
- Substance-related disorders
- Other conditions that may be a focus of clinical attention, unless they co-occur with another (SED)

**Service Plan:** A Service Plan is a plan of services for HCBS members. Your service plan is based on your needs and goals. It is created by you and your interdisciplinary team to meet HCBS Waiver criteria.

**Skilled Nursing Care:** Services from licensed nurses in your own home or in a nursing home.

**Skilled Nursing Facility Level of Care:** Skilled Nursing Facility Level of Care describes the type and amount of skilled nursing care a nursing facility resident needs.

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

**Supported Employment:** Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

**Urgent Care:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

MOLINA®
HEALTHCARE