Welcome to the **Molina family**

Molina Healthcare STAR+PLUS Member Handbook

April 2024
(866) 449-6849

MolinaHealthcare.com

MOLINA® HEALTHCARE
Your Extended Family.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

TEXAS STAR+PLUS
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

Important Phone Numbers

Molina Member Services Department Toll Free: (866) 449-6849

We are open Monday through Friday from 8:00 am to 5:00 pm, local time except on holidays. If you call when this department is closed, you can leave a message on our answering machine. Someone will call you back by the next business day. We also have a service called the 24-hour Nurse Advice Line that you can call. The Nurse Advice Line is available to you 24 hours a day, 7 days a week. They can help you with general information about your health or help you decide where to go for care after-hours.

We can help you in English and Spanish. We have interpreter service agents that can help with any other language. Members who are deaf or hard of hearing can call Relay Texas TTY at 711 (English) or (800) 662-4954 (Spanish).

Molina Member Services Department Toll Free:	**(866) 449-6849**
24-hour Nurse Advice Line Call for basic health questions or if you want information on how to get after-hours care	(888) 275-8750 (English) (866) 648-3537 (Spanish)
Relay Texas TTY For members who are deaf or hard of hearing	711 (English) (800) 662-4954 (Spanish)
Eye Care Services Call for information on routine eye care	(866) 449-6849
Disease Management	(866) 891-2320
Prescription Drugs	(866) 449-6849
Behavioral Health Services (includes mental health and substance abuse) • Behavioral Health Service employees are ready to help you 24 hours a day, 7 days a week • You do not need to ask your doctor to get behavioral health services; you can call member services • Get help with finding a provider that best meets your needs • We can help you in English and Spanish • Interpreter service will be used for any other language • Members who are deaf or have a hard time hearing can call the Relay Texas TTY number above If you are in a critical situation, go to an emergency room that is close to where you are.	
Behavioral Health Services Customer Service Line	(866) 449-6849
Behavioral Health Services Crisis Line (24 hours a day, 7 days a week)	(800) 818-5837
Service Coordination Monday thru Friday, 8:00 a.m. - 5:00 p.m., local time.	(866) 409-0039

Dental Services	(866) 449-6849
Ombudsman Manage Care Assistance Team: Call if you have questions about the STAR+PLUS program or about your health plan. This line does not give medical advice.	1-866-566-8989
STAR+PLUS Program Helpline Call if you have questions on enrollment, plan changes, your primary care provider or health plan.	1-800-964-2777 TTY# 1-800-267-5008
Non-Emergency Medical Transportation To Schedule a Ride: Where's My Ride: Call Access2Care to set up a ride for non-emergency health care visits or to find out where your ride is. Access2Care is available to help you 24 hours a day, 7 days a week. Member Services is also available to assist you in accessing your NEMT services from 8 a.m. – 6 p.m., central time, Monday to Friday. We can help you in English and Spanish. We have interpreter service agents that can help with any other language.	 (866) 462-4857 (866) 462-4857 - Option 2 TTY: 711

What do I do in an Emergency?

Call 911 or go to the nearest hospital/emergency facility if you think you need emergency care and help getting to the emergency room. If you get emergency care, call your doctor to schedule a follow up visit. Call Molina at (866) 449-6849 and let us know of the emergency care you received.

What if I need hospital care?

Sometimes you need hospital care. Sometimes hospital care is not an emergency. If this happens, call your doctor. Your doctor will need to arrange for hospital care that is not an emergency. Molina may need to approve this. Emergency care does not need approval from Molina. Emergency care does not need to be approved by your doctor.

Table of Contents

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Introduction

Welcome to Molina!

Welcome to Molina Healthcare of Texas (Molina). Thank you for picking us as your health plan. You are now a member of a health plan also known as the STAR+PLUS program.

We want to do all we can to help you with your medical needs. We will work with you and your doctor to make sure you get the care you need. We want to help remove any difficulties you have getting health care. We have employees ready to help you with questions or concerns; do not hesitate to call us.

This member handbook can help you with questions you have about how to get health care, what your benefits are, and many other topics. If you need help with this handbook, you can call us toll free at (866) 449-6849.

You can also ask for this handbook in other forms, which include audio, large print, Braille, and other languages. Member Services can help you get one of these handbooks. Just call us and tell us which kind you need.

You can also find information about us on the Internet. Our web site is: www.MolinaHealthcare.com.

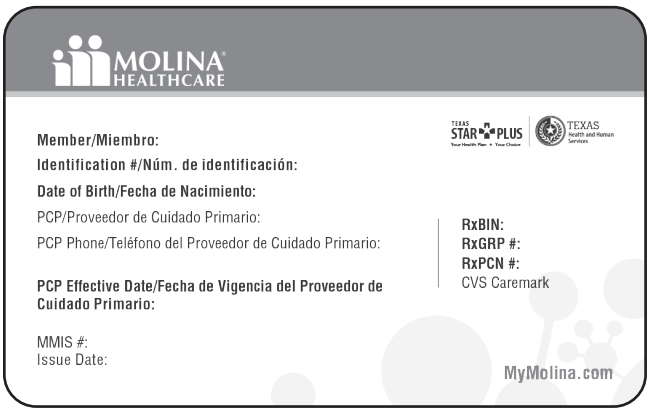
Molina Member Services is Here for You!

We are open Monday through Friday from 8:00 am to 5:00 pm, (local time) except on holidays. We have employees that are ready to help you in English and Spanish. If you speak a language other than English, call Member Services. We have an interpreter service that can help with any other language.

Member Services Toll Free: (866) 449-6849

Molina ID Cards

STAR+PLUS Member Identification Card (ID)

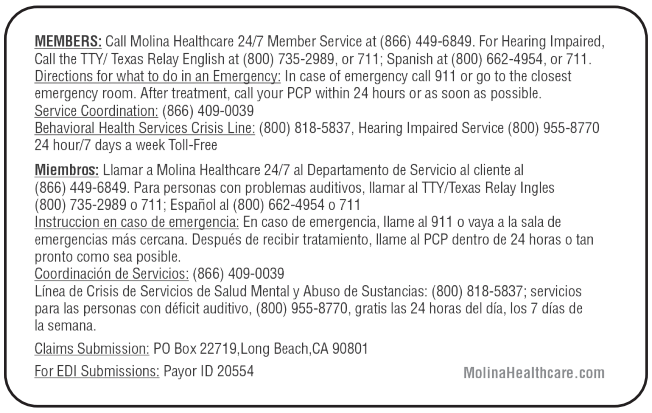


How to read your card

Front	Back
Name of Health Plan and Program Name	Member Services Contact Information
Member Name, Member Identification Number and Date of Birth	What to do in an emergency
Name/Phone Number of Primary Care Physician	Prior Authorization Information
Date the ID Card was Issued/Effective Date of Primary Care Physician	Behavioral Health Contact Information

If you have Medicare and Medicaid, your Molina ID card will not show doctor's name or phone number. Your ID card will show Long Term Care services only.

STAR+PLUS DUAL Medicaid ID Card



How to read your card

Front	Back
Name of Health Plan and Program Name - STAR+PLUS	Member Services Contact Information
Member Name, Member Identification Number and Date of Birth	What to do in an emergency
Long Term Services and Supports	Service Coordination
Date the ID Card was issued	Behavioral Health Contact Information

If you have Medicare, your ID card will not show a primary care provider. It will show "Long Term Care Benefits Only".

How to use your ID card?

Show your ID card whenever you are getting health care services. You will also need to show Your Texas Benefits Medicaid Card. You should carry it with you all the time. You do not need to show your ID card before getting emergency care.

How to replace a lost or stolen ID card?

If your ID card has been lost or stolen, call Member Services toll free at (866) 449-6849. You can get a new ID Card.

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a Your Texas Benefits Medicaid Card. This plastic card will be your everyday Medicaid ID card. You should carry and protect it just like your driver's license or a credit card. The card has a magnetic strip that holds your Medicaid ID number. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will only be issued one card, and will only receive a new card in the event of the card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free 1-800-252-8263, or by going online to order or print a temporary card at www.YourTexasBenefits.com.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 2-1-1. First pick a language and then pick option 2.

Your health history is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your health history through the secure online network, call toll-free at 1-800-252-8263.

The Your Texas Benefits Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Texas Women's health Program (TWHP)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE).
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the Your Texas Benefits Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card.

If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

YourTexasBenefits.com Medicaid Client Portal

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

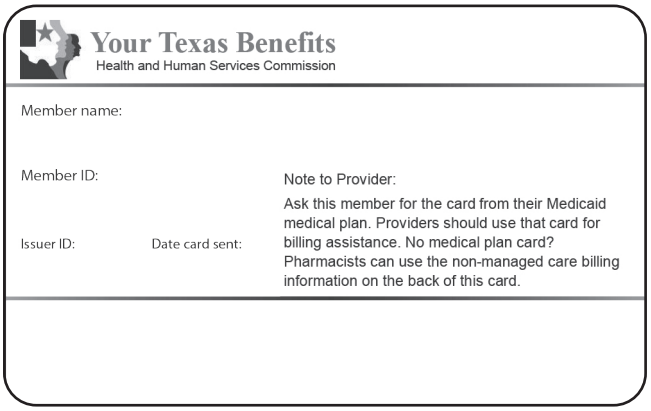
- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

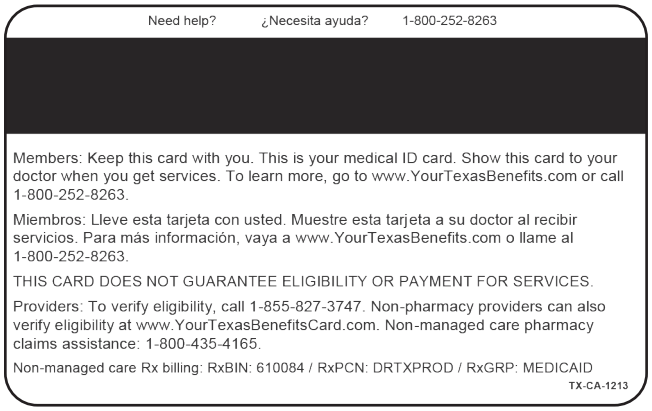
To access the portal, go to www.YourTexasBenefits.com.

- Click Log In.
- Enter your User name and Password. If you don't have an account, click Create a new account.
- Click Manage.
- Go to the "Quick links" section.
- Click Medicaid & CHIP Services.
- Click View services and available health information.

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active clients only. A Legally Authorized Representative may view the information of anyone who is a part of their case.

Sample of Your Texas Benefits Medicaid Card:





Temporary Verification Form - Form 1027-A

If you lose Your Texas Benefits Medicaid card you will have to visit your local Health and Human Services Commission (HHSC) Benefits Office or call 1-800-252-8263 or call 2-1-1. HHSC will provide you with a temporary verification form called a Form 1027-A. You can use this form until you receive Your Texas Benefits Medicaid Card.

Primary Care Provider (PCP)

What is a Primary Care Provider?

A Primary Care Provider is your main doctor. It can also be nurse or clinic. This doctor knows you well. Your main doctor will treat most of your healthcare needs. If he cannot, you will be referred to a provider who can. Your doctor's name and telephone number are on your ID card.

NOTE: If you have Medicare and Medicaid, Medicare pays your doctor. You don't need to pick a Molina doctor or primary care provider. You can keep going to your Medicare doctor.

How do I get medical services?

You should get all health care from Molina providers. Your Provider Directory lists all the providers that participate in the organization, which includes a list of contracted provider's names, specialties, addresses, telephone numbers, and professional qualifications such as medical school, residency and board certification status. The provider directory can be found on our website or if you would like a copy, you may call Member Services at (866) 449-6849. Your PCP can help you with the following:

- Checkups
- Tests and Results
- Lab tests
- Shots
- Illnesses
- Specialist Visits
- Hospital Visits

If you also have Medicare, you do not need to pick a Molina doctor or a primary care physician.

What do I need to bring with me to my doctor's appointment?

You must take your Molina ID card and Your Texas Benefits Medicaid Card whenever you go to the doctor or get any health care services.

How can I change my Primary Care Provider?

If you want to change your primary care provider, just call Member Services toll free at (866) 449-6849. Molina can help you find a new primary care provider.

Can a clinic be my primary care provider? (Rural Health Clinic/Federally Qualified Health Center)

Yes, a primary care provider can also be a clinic, such as a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

How many times can I change my/my child's primary care provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us at (866) 449-6849 or writing to:

Molina Healthcare of Texas
Attn: Enrollment Department
1660 N. Westridge Circle
Irving, TX 75038-2617

When will my primary care provider change become effective?

Your primary care provider change will be effective on the first day of the month following the month you made the request.

Are there reasons why my request to change a primary care provider may be denied?

Yes, your request to change a doctor may be denied if:

- The primary care provider you want is not taking new patients.
- The primary care provider you want is no longer with Molina.

Can a primary care provider ask to move me to another primary care provider for non-compliance?

Yes, your primary care provider may request a change if:

- You often miss visits and don't call your primary care provider to say you will not be there.
- You do not follow your primary care provider's advice.
- You and the primary care provider do not get along.

What if I choose to go to another doctor who is not my primary care provider?

You may go to any doctor who is not your primary care provider if you need:

- 24-hour emergency care from an emergency room
- Behavioral Health Care
- OB/GYN Care
- Texas Health Step Services

You should go to your primary care provider for most other services. If your primary care provider does not give a service, you will be referred to one who does.

How do I get medical care after my Primary Care Provider's office is closed?

Your primary care provider will have someone help you after their office is closed. Only call after hours if you have an urgent care need. If it is an emergency, go to the nearest emergency room or call 911.

Your primary care provider's phone number is on the front of your Molina ID card. You can also call our 24-hour Nurse Advice Line. When you call them, tell them what your medical problem is. They will help you decide the best way to get your medical needs taken care of.

NOTE: If you are also covered by Medicare, you will not be assigned a doctor and their phone number will not be on your ID card.

What is the Medicaid Lock-in Program?

You may be put in the Lock-in Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.

- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more call Molina Member Services toll free at (866) 449-6849.

If you are in the Lock-In Program and need help getting outpatient drugs in an emergency situation, call Member Services. We can help you. If you are in an emergency situation and need medical care immediately, go to the nearest Emergency Room or call 911.

Physician Incentive Plans

Molina cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call (866) 449-6849 to learn more about this.

Changing Health Plans

What if I want to change health plans? When will my health plan change become effective? Who do I call?

You can change your health plan by calling the Texas STAR, STAR Kids or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want.

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

How many times can I change health plans?

You can change plans as many times as you want, but not more than once a month.

Can Molina request that I be dropped from their plan (for non-compliance, etc.)?

Yes, Molina can ask that you be disenrolled from the health plan if:

- You let someone else use your Molina Healthcare of Texas ID card
- You let someone else use your Texas Benefits Medicaid Card or
- You make it difficult for your doctor to help you

The Texas Health and Human Services Commission will make the final decision on all disenrollment requests. If there is a change in your health plan, you will be sent a letter.

Note: For STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned.

Benefits

What are my health care benefits?

Here is a list of ***some*** of the medical services you can get from Molina. Some of your benefits do have limits. Call Molina Member Services toll free at (866) 449-6849 for more information.

Your Benefits	
Emergency and non-emergency ambulance services	Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program
Audiology Services	Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
Behavioral Health services	Outpatient drugs and biologicals
Birthing services provided by a physician and Certified Midwife (CNM) in a licensed birthing center	Drugs and biologicals provided in an Inpatient setting
Birthing services provided by a licensed birthing center	Podiatry
Cancer screening, diagnostic, and treatment services	Prenatal Care
Chiropractic services	Primary Care services
Dialysis	Preventive services including an annual adult well-check, for patients 21 years of age and over
Durable medical equipment and supplies	Radiology, imaging, and x-rays
Early Childhood Intervention (ECI) services	Specialty physician services
Emergency services	Therapies – physical, occupational and speech
Family planning services	Transplantation of organs and tissues
Home health care services	Vision (includes optometry and glasses)
Hospital services, including inpatient and outpatient	Telemedicine
Laboratory	Telehealth
Mastectomy/breast reconstruction, and related follow-up procedures	Nursing Facility services
Immobilized Lipase Cartridges – Effective March 1, 2021	Medical Physics Consultations – Effective March 1, 2021
Community Based Long Term Care Services such as:	
Personal Attendant Services (PAS)	Day Activity and Health Services (DAHS)
Home and Community Based Services (HCBS) STAR+PLUS Waiver services such as:	
Personal Attendant Services (PAS)	In-home or out-of-home respite services
In-home nursing services	Emergency Response services (ERS)
Home Delivered Meals	Minor home modifications
Adaptive aids and medical equipment, medical supplies	Adult Foster Care (AFC)
Assisted Living	Transitional Assistance Services (TAS)

Your Benefits	
Therapy (occupational, physical and speech)	Day Activity and Health Services (DAHS)
Dental services	Cognitive rehabilitation services
Financial management	Support consultation
Employment assistance	Supported employment
Community First Choice (CFC) services such as:	
Personal Assistance Services (PAS)	Acquisition, maintenance and enhancement of skills
Emergency Response Services (ERS)	Support management

How do I get these services?

Your Primary care provider will do most services. If your primary care provider does not give you a service, you will be sent to a provider that can. If you have an emergency, go to the nearest Emergency Room.

Are there any limits to any covered services?

Some of the covered services may have limitations. For questions about a specific service, call Member Services Toll Free at: (866) 449-6849.

What services are not covered?

Services that are not covered by Medicaid will not be covered by your Molina health plan. Some of the services that are not covered are listed below. You can call Member Services for a complete list of services that are not covered.

- Acupuncture
- Plastic or cosmetic surgery that is not medically necessary
- Surrogacy

If you have a question about a service being covered, call Molina Member Services at (866) 449-6849 and ask for help. If you have a service done that is not covered, you may have to pay for it.

What are my prescription drug benefits?

Prescription drugs are covered when:

- The drug is on the Texas Vendor Drug Formulary
- The prescription is filled at a network pharmacy
- They are ordered by your PCP or another doctor treating you or your child.

You can look for the Guide to Accessing Quality Healthcare, located on the Quality Improvement Program section of our website, MolinaHealthcare.com, or call Member Services if you want to know more about your drug benefits and the pharmacy process.

Will my STAR+PLUS benefits change if I am in a Nursing Facility?

Your STAR+PLUS benefits will not change if you are in a Nursing Facility. For more information, call your Service Coordinator at (866) 409-0039, or Member Services at (866) 449-6849.

Medicaid for Breast Cancer and Cervical Cancer (MBCC)

Women in the Medicaid for Breast and Cervical Cancer (MBCC) program will receive all their Medicaid services, including cancer treatment, through the STAR+PLUS Medicaid managed care program.

What is MBCC?

MBCC provides Medicaid to women diagnosed with breast or cervical cancer or certain pre-cancer conditions. Women enrolled in MBCC must re-enroll in the program every 6 months to maintain their eligibility to continue full Medicaid benefits.

A woman can get MBCC services if she is:

- Uninsured
- Between the ages of 18 until the month she turns 65
- A U.S. citizen or a qualified immigrant
- A Texas resident
- At or below 200% of the federal poverty level

What services am I eligible for as an MBCC member?

You will receive all the Medicaid services including cancer treatment through STAR+PLUS. Through the STAR+PLUS program, you will receive:

- Unlimited prescriptions
- A Service Coordinator to help you find the right providers for all your needs
- A Primary Care Provider (PCP) to make sure all of your needs are addressed
- Value Added Services, these are extra services for Molina members at no extra cost

Can I continue to see the same providers?

You can continue to see your doctor if they are part of Molina's network of providers. If your doctor is not part of our network, you can continue to see them for 90 days, after that you will have to find a new doctor. Molina Member Services can help you find a new doctor. Molina will honor all authorizations for six-months, until the authorization expires, or until a new one issued.

Who can I call if I have questions?

You can call Member Services at (866) 449-6849, Monday to Friday, 8:00 a.m. – 5:00 p.m., local time. You can also call Service Coordination at (866) 409-0039.

Acute Care Benefits

What are my Acute Care benefits?

Acute care benefits include services like doctor visits, x-rays, labs, and other medical benefits. For more information on acute care benefits call your Service Coordinator at (866) 409-0039, or Member Services at (866) 449-6849. Please remember that if you have Medicare and Medicaid your acute care benefits are covered by Medicare.

How do I get these services? What number do I call to find out about these services?

Call your primary care provider and let the office know what service you need. Your doctor will help you get the services you need. For some of the services listed you can go directly to the provider that gives the services. Call your Service Coordinator at (866) 409-0039, or Member Services at (866) 449-6849.

NOTE: Please remember that if you have Medicare the acute care benefits are covered by Medicare.

Long-Term Care and Support (LTSS) Benefits

What are my Long-Term Care and Support (LTSS) Benefits?

Long Term Care services and Supports are benefits that help you stay safe and independent in your home or community. You can get Long Term Care services if you need help with daily healthcare and living needs. Some of the services include helping you dress, bathe, or go to the bathroom; preparing meals; doing light housework; or helping with your grocery shopping.

Other STAR+PLUS, Long Term Care and Support (LTSS) Benefits:

Some STAR+PLUS members can get other long term care services that are based on their medical need. These are called STAR+PLUS Waiver Services (you may have heard of these services called CBA):

- Adaptive aids such as: wheelchairs, walkers, canes, and durable medical equipment
- Adult Foster Care
- Assisted Living Services
- Consumer Directed Services
- Emergency Response Services
- Home Delivered Meals
- Minor Home Modifications
- Nursing Facility Services
- Personal Care Attendant
- Respite Care Services
- Therapy Services (physical, occupational, speech)
- Protective Supervision
- Transition Assistance Services
- Dental Services
- Cognitive Rehabilitation Therapy

How do I get these services? What number do I call to find out about these services?

You can get information about these services by calling Member Services Toll Free at: (866) 449-6849. You can also contact a member of the Service Coordination team at (866) 409-0039.

Community First Choice (CFC)

What is Community First Choice (CFC)? Who is eligible for CFC Services?

Community First Choice benefits provide home and community-based supports and services to certain Medicaid members with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities.

Members who need an institutional level of care (example: hospital, nursing facility, intermediate care facility, etc.) and who need help or want to become more independent may be eligible for CFC Services. Members living in a community-based home may be able to get these services. Call Member Services for more eligibility information.

What CFC services are available?

CFC provides services such as:

- Personal assistance services (PAS): help with daily living activities and health-related tasks
- Habilitation Services: services to help members learn new skills and care for themselves
- Emergency Response Services: help if members live alone or are alone for most of the day
- Support Management: training on how to select, manage and dismiss attendants

If you think you need CFC services, your Service Coordinator will be able to help schedule an assessment. If you have questions about CFC services and/or eligibility, call your Service Coordinator or Member Services.

Value Added Benefits

What extra benefits does a member of Molina Healthcare get?

At Molina Healthcare, we care about your health. That's why we focus on getting you the Value Added Services, quality care and support you need to stay healthy. All at no cost to Molina members! Call Member Services to get more information on these benefits. A full list of Value Added Services, including any limitations or restrictions, is located on page 40 of this handbook. This list is also available on our website at MolinaHealthcare.com.

How can I get these benefits?

We can help you get these services. Your Value Added Services and member handbook are updated from time to time. You can find the most current versions on our website by visiting MolinaHealthcare.com, or by calling Member Services at (866) 449-6849. We can mail a copy of the most current versions to you.

What health education classes does Molina Healthcare offer?

Molina wants to help keep you and your family healthy. We can help you find health education classes near your home. Call Member Services to find out about these classes.

Some of the classes are:

- Quitting Smoking
- Losing weight
- Pregnancy and Childbirth
- Infant care
- Parenting

Disease Management

We also have programs to help you manage certain health conditions. Some of these conditions are Asthma, Cardiovascular Disease, Congestive Heart Failure, COPD and Diabetes; we also have a special program to help you if you are pregnant. The programs offer learning materials, telephonic calls, and advice. You can take part in a way that best manages your needs.

You will be enrolled if you have any of the health conditions listed above. You will begin to receive learning materials and newsletters. If you or your child's condition is more severe, you may receive a telephone call by a Case Manager or Service Coordinator. They will work with you and your doctor to help make sure you have what

you need to stay well. If you would like to know more about any of these programs, please call Member Services at (866) 449-6849.

What other services can Molina help me get? (Non-capitated services)

Molina can help you get some services covered by fee-for-service Medicaid instead of Molina. Below are some of those agencies that cover service that Molina can help you get:

- Texas Health Steps dental (including orthodontia);
- Texas Health Steps environmental lead investigation (ELI);
- Early Childhood Intervention (ECI) Program;
- Texas School Health and Related Services (SHARS);
- Texas Department of Assistive and Rehabilitative Services (DARS)
- Blind Children's Vocational Discovery and Development Program;
- Food Stamps,
- Women, Infants, and Children's (WIC) Program,
- Case Management for Children and Pregnant Women;

Call your Service Coordinator at (866) 409-0039 for information about these services or how to get these services. Or call Member Services Toll Free at (866) 449-6849.

Health Care and Other Services

What does Medically Necessary Mean?

Medically Necessary means:

1. For Members birth through age 20, the following Texas Health Steps services:
   a. Screening, vision, and hearing services; and
   b. other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
      i. must comply with the requirements of the Alberto N., et al. v. Janek, et al. partial settlement agreements; and
      ii. may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.
2. For Members over age 20, non-behavioral health related health care services-that are:
   a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
   b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
   c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d. consistent with the diagnoses of the conditions;
   e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f. not experimental or investigative; and
   g. not primarily for the convenience of the member or provider; and

3. For Members over age 20, behavioral health services that:
   a. are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   b. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
   d. are the most appropriate level or supply of service that can safely be provided;
   e. could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
   f. are not experimental or investigative; and
   g. are not primarily for the convenience of the member or provider.

What is routine medical care?

Routine medical care is when you go to your primary care provider for a check-up, without being sick. This care is important to keep you in good health. Some of the things that can be done on these visits are well woman exam, Texas Health Steps medical check-up for your child or a full routine physical.

How soon can I expect to be seen?

When you call your primary care provider for routine medical care, you will get an appointment within 14 days from the day you call.

What is urgent medical care?

Another type of care is urgent care. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts
- Earaches
- Sore throat
- Muscle sprains/strains

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Molina Medicaid. For help, call us toll-free at (866) 449-6849. You also can call our 24-hour Nurse Advice Line at (888) 275-8750 for help with getting the care you need.

How Soon Can I Expect to Be Seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Molina Medicaid.

What is Emergency Medical Care?

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

Emergency Medical Condition means:
A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergency Behavioral Health Condition means:
Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

1. requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
2. which renders the Member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency Services and Emergency Care means:
Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post-stabilization care services.

How soon can I expect to be seen?

You should be seen as soon as possible. The emergency room staff will decide based on your condition. If you need help getting to the emergency room, call 911.

What is Post-Stabilization?

Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

What if I get sick when I am out town or traveling?

If you need medical care when traveling, call us toll free at (866) 449-6849 and we will help you find a doctor. If you need emergency services while travelling, go to a nearby hospital, then call us Toll Free at (866) 449-6849.

What if I am out of State?

If you need medical care when you are out of the state, call us toll-free at (866) 449-6849 and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at (866) 449-6849.

What if I am out of the country?

Medical services performed out of the country are not covered by Medicaid.

What if I am a Migrant Farm Worker?

You can get your checkup sooner if you are leaving the area.

Specialist Care

What if I need to see a special doctor? (Specialist)

Your primary care provider will help you if you need to see a special doctor or if you need a special service. Your primary care provider will make sure you get the special health care you need. Please remember that if you have Medicare and Medicaid the acute care benefits are covered by Medicare.

How soon can I expect to be seen by a specialist?

When you call to make an appointment with a specialist, you will be seen within (30) days. If your medical need is urgent you will be seen within (24) hours.

Can a specialist ever be considered a Primary Care Provider?

Yes, if you would like a specialist to be your primary care provider and the doctor agrees, you can call member services toll-free at (866) 449-6849 for help.

What is a referral?

A "Referral" is an approval for you to get certain medical services. Molina does not require referrals; however, some services may require Prior Authorization (PA). Your primary care provider will help you get PA if it is needed.

What Services Do Not Need A Referral?

Molina does not require referrals; however some services require Prior Authorization (PA). If you are not sure if a service needs PA, call Member Services.

Second Opinion

How can I ask for a second opinion?

To ask for a second opinion, call Member Services. They will help you. Your doctor can also call and ask that you have a second opinion.

Listed below are some of the reasons why you may want to have a second opinion:

- You are not sure if you need the surgery your doctor is planning to do
- You are not sure of your doctor's diagnosis or care plan for a serious or difficult medical need
- Your doctor is not sure of a diagnosis because your condition is confusing
- You have done what the doctor has asked, but you are not getting better

When a doctor does a second opinion, he or she will give a written report to you and your first doctor

General Health Care Tips

- Be active in your health care: Plan ahead
- Schedule your visits at a good time for you
- Ask for your visit at a time when the office is least busy if you are worried about waiting too long
- Keep a list of questions you want to ask your doctor
- Refill your prescription before you run out of medicine

Make the most of your doctor's visit

- Make a list of questions you want to ask before you go to your appointment
- Ask your doctor questions.
- Ask about possible side effects of any medicines you have been prescribed.
- Tell your doctor if you are drinking any teas or taking herbs. In addition, tell your doctor about any vitamins or over-the-counter medicines you are using.

Visiting your doctor when you are sick:

- Try to give your doctor as much information as you can.
- Tell your doctor if you are getting worse or if you are feeling about the same.
- Tell your doctor if you have taken anything
- Remember to take your medications with you to all appointments with your doctor

Behavioral Health, Mental Or Substance (Drug) Abuse

How do I get help if I have behavioral (mental) health, alcohol or drug problems?

Call our Behavioral Health Customer Service Line at (866) 449-6849. You do not need to call your primary care provider to get an approval for these services. If you have an emergency or crisis care need, you do not need to call first, go to the nearest emergency care center or call 911. You can also call our 24-hour Behavioral Health Crisis Line at (800) 818-5837. Someone will always be there to help you.

Do I need a referral for this?

No, you do not need to get a referral from your primary care provider for these services.

What are mental health rehabilitation services and mental health targeted case management? How do I get these services?

Mental Health Rehabilitation and Targeted Case Management services are available to adult Medicaid recipients who are assessed and determined to have a severe and persistent mental illness (SPMI) illness (such as Schizophrenia, Major Depression, Bipolar Disorder), as well as children and adolescents ages 3 through 17 years with a diagnosis of a mental illness who exhibit a severe emotional disturbance (SED) (such as Conduct Disorder). For more information, call Molina Member Services at (866) 449-6849, or your Service Coordinator at (866) 409-0039.

Prescription Drugs

How do I get my medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

How do I find a network drug store?

You have to go to a Molina network pharmacy. You can get your prescription filled at most drug stores in Texas, including Walgreens, Kroger, HEB, Randall's, Target, Wal-Mart, CVS. If you need help with finding a pharmacy, just call Member Services toll free at (866) 449-6849. You can also go to the internet. Our website is www.MolinaHealthcare.com. You can click on the find a pharmacy link. This will show you the list of pharmacies.

What if I go to a drug store not in the network?

You have to go to a Molina pharmacy for your prescriptions to be covered, and we can help you find one. Just call Member Services toll free at (866) 449-6849.

Call us if you are out of state and need emergency prescriptions. We can help you find a Molina pharmacy. If there are no Molina pharmacies, you can use an in-network mail order pharmacy or an in-network pharmacy to deliver your prescriptions to your preferred address at no cost.

What do I bring with me to the drug store?

You have to take your Molina ID card, Your Texas Benefits Medicaid Card, and the prescription your doctor wrote for you.

What if I need my medications delivered to me?

If you cannot leave home, Molina can provide you with mail order pharmacy. This is done by CVS Caremark Mail Services. Please call Molina Member Services Toll Free at (866) 449-6849.

Who do I call if I have problems getting my medications?

We can help you. Call Member Services at (866) 449-6849.

If you have both Medicare and Medicaid, your prescriptions are covered by Medicare. Molina may cover out-of-pocket costs for some medications.

What if I can't get the medication my doctor ordered approved?

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call Molina at (866) 449-6849 for help with your medications and refills.

What if I lose my medication(s)?

If your medication is lost or stolen, have your pharmacy can call Molina Member Services at (866) 449-6849 for help.

What if I need durable medical equipment (DME) or other products normally found in a pharmacy?

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, Molina pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Molina also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call Molina (866) 449-6849 for more information about these benefits.

Where can I find answers to drug benefits?

You should speak with your provider about any medication you need. You can visit our website if you want to know more about your drug benefits, the pharmacy process or for more information. Look for the Guide to Accessing Quality Healthcare, located on the Quality Improvement Program section of our website or call Member Services at (866) 449-6849.

What if I also have Medicare?

If you have Medicaid and Medicare, you will get your prescriptions from Medicare. Molina may cover your out-of-pocket costs for some medications.

How do I get my medications if I am in a Nursing Facility?

You may have your medication filled at any Molina Network Pharmacy.

- A family member or someone you choose could bring the medication to you.
- You may have the medication mailed to you from our mail order pharmacy.
- Some local pharmacies offer delivery service.

*Check with the nursing facility to see which method meets their rules.

Family Planning Services

How do I get family planning services?

Family planning services like birth control and counseling are private; you do not need to ask your doctor to get these services. You can go to any family planning provider who takes Medicaid.

Do I need a referral for this?

No, you do not need to ask your primary care provider to get these services.

Where do I find a family planning service provider?

You can find the locations of family planning providers near you online at www.dshs.state.tx.us/famplan/ or you can call Molina at (866) 449-6849 for help in finding a family planning provider.

Case Management For Children And Pregnant Women (CPW) Program

What is Case Management for Children and Pregnant Women (CPW)?

CPW gives service to children with a health need or risk, birth through 20 years of age and to high-risk pregnant women of all ages.

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems, or
- Are at a high risk for getting health problems

What do case managers do?

A case manager will visit you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?

Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?

Contact Molina Healthcare for more information or call Texas Health Steps at (877) 847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

- Molina Healthcare Case Management Phone Number: (866) 449-6849,
- Molina Healthcare website: www.MolinaHealthcare.com

What is Early Childhood Intervention (ECI)?

Early Childhood Intervention (ECI) is a statewide program for families with children, up to three years old, who have disabilities or developmental delays. ECI provides evaluations and assessments, at no cost to Molina families, to determine eligibility and need for services. ECI goes to families and focuses on working with the child and family in their natural environment, such as at home, grandma's house or a child care center.

Early Childhood Intervention responds to the critical needs of children and families by:

- Promoting development and learning,
- Providing support to families,

- Coordinating services, and
- Decreasing the need for costly special programs

ECI services feature:
- Individualized Planning Process
- Family-Centered Services
- Case Management
- Familiar Settings
- Professional Providers
- Plans for Continuing Services

For more information about ECI or to refer a child, call Member Services at (866) 449-6849 or the DARS Inquiries Line at (800) 628-5115.

Do I need a referral for this?

A medical diagnosis or a confirmed developmental delay is not needed to refer. As soon as a delay is suspected, children may be referred to ECI, even as early as birth.

Where do I find an ECI provider?

To locate the ECI program that serves your area, visit the Texas Department of Assistive and Rehabilitative Services (DARS) website at https://citysearch.hhsc.state.tx.us/, select the city or county where you live from the drop-down menu and click the "Search" button.

One or more ECI programs will appear along with the address, phone numbers, email and Web site (if available). There may be several ECI programs in your city or county. To narrow your search, follow the directions on the website.

You can also call Member Services for help finding an ECI provider.

Service Coordination

What is Service Coordination?

Service Coordination is a special service for STAR+PLUS members to help you manage your health, long- term service and supports and behavioral health care needs. When you enroll with Molina, you will be assigned to a Service Coordinator. The Service Coordinator's job is to help you with all of your health care needs.

What will a Service Coordinator do for me?

Your Service Coordinator will:
- Call and get to know you and your health care, long-term service and supports, and behavioral health care needs
- Use a "screening survey" to help decide if you need more help right away
- Talk with any case managers, providers, pharmacists or other persons that you say are important for your care needs
- Help you find the services you need
- Write a service plan with you and your Primary Care Provider's help
- Stay in contact with you to check up on your health and keep track of your service plan

How can I talk with a Service Coordinator?

You can contact your Service Coordinator by phone with questions and concerns. Call (866) 409-0039 to contact your Service Coordinator.

How can I get Service Coordinator?

You can call Molina at (866) 409-0039 to as for Service Coordination.

Transportation

Non-Emergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to nonemergency health care appointments for Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT Services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health care service is confidential in nature.

How to get a ride

Your MCO will provide you with information on how to request NEMT services. You should request NEMT Services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical

supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

You must notify your MCO prior to the approved and scheduled trip if your medical appointment is cancelled.

Who Do I call for a ride to a medical appointment?

You can contact Access2Care at (866) 462-4857 to schedule transportation to non-emergency health care appointments. Access2Care is available to schedule your transportation services 24 hours a day, 7 days a week. Please be sure to schedule your transportation services as early as possible, and at least 48 hours in advance.

Vision

How do I get eye care services?

You can get routine eye care. You have to go to a vision care provider. The provider list is in the Vision Section of your Provider Directory. You will not need a referral from your primary care provider for routine vision care. If you have a medical problem with your eyes, you will need to call your primary care provider first. If your doctor cannot treat your medical problem, you will be referred to a special eye doctor who can. Adult members age 21 years and older get a vision exam and medically necessary frames and certain plastic lenses every 24 months.

Dental Services

What dental services does Molina cover for children?

Molina covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

- Treatment of dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

Molina covers hospital, physician, and related medical services for the above conditions. This includes services the doctor provides and other services your child might need, like anesthesia or other drugs.

Molina is also responsible for paying for treatment and devices for craniofacial anomalies.

Your child's Medicaid dental plan provides dental services including services that help prevent tooth decay and services that fix dental problems. Call your child's Medicaid dental plan to learn more about the dental services they offer.

For STAR+PLUS Waiver members who are adults and who need dental services, you must receive services from a dentist contracted with the Molina dental plan. When dental services require anesthesia in an outpatient or ambulatory care setting, your dental services are paid through the dental benefit available to you. The anesthesia is paid under the Medicaid benefit. If you have Medicare, the anesthesia is covered by Medicare.

Are Emergency Dental Services Covered by the health plan?

Molina covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for a dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Hospital, physician, and related medical services such as drugs for any of the above conditions.

What do I do if my child needs Emergency Dental Care?

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll free at (866) 449-6849 or call 911.

Interpreter Services at Doctor's Visits

Can someone interpret for me when I talk with my doctor? Who do I call for an interpreter?

When you set up a medical visit, tell the provider you need an interpreter. If the provider does not have someone to interpret for you, call Molina Member Services at (866) 449-6849; we will help you.

How far in advance do I need to call to get an interpreter?

Call as soon as you make a doctor's appointment.

How can I get a face-to-face interpreter in the provider's office?

When you call to set up your visit, tell the person you are talking to that you need an interpreter with you during the visit. If they cannot help, call Member Services.

OB/GYN Care

What if I need OB/GYN care? Do I have the right to choose an OB/GYN?

Attention Female Members

Molina Healthcare of Texas allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not. You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to other special doctors within the network.

How do I choose an OB/GYN?

You can pick any OB/GYN listed in the Molina Provider Directory. Your OB/GYN will set up an appointment within two (2) weeks of your call.

If I do not choose an OB/GYN, do I have direct access? Will I need a referral?

You have direct access to see an OB/GYN without a referral from your primary care provider. You can go to any OB/GYN provider listed in the Provider Directory.

How soon can I be seen after contacting my OB/GYN for an appointment?

You will be seen within two (2) weeks from the day you called to set up your visit.

What if I am pregnant? Who do I need to call?

Please call Molina as soon as you know you are pregnant. Molina will help you get the care you need.

Our educational pamphlets, and other information, will answer any questions you may have about the pregnancy.

Can I stay with an OB/GYN who is not with Molina?

You can see a doctor who is not part of Molina's network if:

- You are in the last three months of your pregnancy when you start your coverage with Molina, or
- if you have a health problem that would make changing to a new doctor unsafe. If not, you will need to see a Molina doctor.

What other services/activities/education does Molina offer pregnant women?

Molina has a program just for pregnant women. This program gives you information on having a healthy pregnancy. It will tell you important things to do for you. It will tell you important things to do for your baby. You will work with someone that will help you during the time you are pregnant. This person will help you with what to do after your baby is born.

Where can I find a list of birthing centers?

Call Member Services at (866) 449-6849 for help with finding a center. You can go to Molinahealthcare.com to find a provider in your area.

Can I pick a Primary Care Provider for my baby before the baby is born? (Does not apply to members who also have Medicare)

Yes, call Member Services. We will help you find a primary care provider for your baby. We will need your name and your member ID number.

How and when can I switch my baby's Primary Care Provider? (Does not apply to members who also have Medicare)

You can switch your baby's Primary Care Provider by calling Member Services. We can help you find a new primary care provider for your baby. You can switch your baby's primary care provider no more than one time per month.

How do I sign up my newborn baby?

It is important to sign your baby up for Medicaid soon after your baby is born. To get more information on how to sign your baby up call the Medicaid Helpline at 1-800-964-2777. The Helpline staff will tell you what you need to do to keep your baby covered under Medicaid. Check with the hospital social worker before you go home to

make sure the application is complete. You can also call 2-1-1 to find your local HHSC office to make sure your baby's application has been received.

How and when do I tell Molina about the birth of my baby?

You need to call Molina's Member Services at (866) 449-6849 to let us know that you had your baby as soon as you can.

How and when do I tell my caseworker?

Call your local HHSC benefits office to let them know that your baby has been born.

How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Texas Women's Health Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Texas Women's Health Program

The Texas Women's Health Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Texas Women's Health Program, write, call, or visit the program's website:

Texas Women's Health Program
P.O. BOX 14000
Midland, TX 749711-9902
Phone: (800) 335-8957
Website: www.texaswomenshealth.org/
Fax: (toll-free) (866) 993-9971

DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent if the federal poverty level). A person approved for the services may have to pay a co-payment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.dshs.texas.gov/chcl/.

To learn more about services you can get through the Primary Health Care program, email, call, or visit the program's website:

Website: www.dshs.state.tx.us/phc/
Phone: (512) 776-7796
Email: PPCU@dshs.state.tx.us

DSHS Expanded Primary Health Care Program

The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breast feeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.dshs.texas.gov/chcl/.

To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call, or email:

Website: www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx
Phone: (512) 776-7796
Fax: (512)776-7203
Email: PPCU@dshs.state.tx.us

DSHS Family Planning Program

The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.dshs.texas.gov/chcl/.

To learn more about services you can get through the Family Planning program, visit the program's website, call, or email:

Website: www.dshs.state.tx.us/famplan/
Phone: (512) 776-7796
Fax: (512)776-7203
Email: PPCU@dshs.state.tx.us

Other Important Information

Who do I call if I have special health care needs and need someone to help me?

You can call Member Services. We will help you get more information on how to get help with special health care needs. We can tell you about services that Molina has in your area. We can tell you of community resources in your area. It is important to tell your primary care provider that you have special health care needs. Call your primary care provider to make an appointment to talk about your special needs.

What if I am too sick to make a decision about my medical care?

You can write a letter that is called an Advance Directive that tells people what you want to happen if you get very sick. For more information on how to write an Advance Directive, call Member Services at (866) 449-6849. We can send you forms to fill out that tell others the kind of health care you want if you are too sick to tell them.

What are Advance Directives?

An Advance Directives is a letter that you write to tell others the type of health care you want if you are too sick. You can also use this letter to give someone else the right to make these decisions for you, if you become too ill to make the decisions yourself.

How do I get an Advance Directive Form?

You can get forms to write advance directives by calling Member Services at (866) 449-6849. They will help you get the information you need to complete these forms.

What do I have to do if I need help with completing my renewal application?

How to Renew
Families must renew Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions. The family needs to:

- Look over the information on the renewal application.
- Fix any information that is not correct.
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, the staff will check to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program (Medicaid or CHIP), HHSC will send the family a letter telling them about the referral, and then look to see if the child can get benefits in the other program. If the child qualifies, the coverage in the new program (Medicaid or CHIP) will begin the month following the last month of the other program's coverage. During renewal, the family can pick new medical and dental plans by calling the CHIP/Children's Medicaid call center at (800) 964-2777.

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

What if I get a bill from my doctor? Who do I call? What information will they need?

The STAR+PLUS Program does not have copays. Your doctor should not bill you for a covered service. If you do get a bill from a doctor, call the doctor's office and make sure they have your Medicaid information and any other insurance policy information available. All of the information your doctor needs to bill Molina for the service is on your ID card.

You can also get help by calling Molina's Member Services. A team member will help you with your doctor bill. To help you, they will need:

- The name of the patient
- The patient's Medicaid ID number
- The date of service
- The name of the doctor sending you the bill
- The amount you are being billed for

Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?

You cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance, and co-payments that are covered by Medicaid.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and Molina Member Services Department at (866) 449-6849. Before you get Medicaid services in your new area, you must call Molina, unless you need emergency services. You will continue to get care through Molina until HHSC changes your address.

What if I have other health insurance in addition to Medicaid?

Medicaid and Private Insurance

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your private health insurance is canceled.
- You get new insurance coverage.
- You have general questions about third party insurance.
- You can call the hotline toll-free at 1-800-846-7307.

If you have other insurance you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

Member Rights and Responsibilities

What are my rights and responsibilities?

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
   c. Be given information about your health plan, services, and providers..
   d. Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an External Medical Review and State fair hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State fair hearing without an External Medical Review from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have a right to make recommendations to your health plan's member rights and responsibilities.

You also have the right to submit a bill for covered services if applicable, please submit to:

Molina Healthcare
PO BOX 22719
Long Beach, CA 90801

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

ADDITIONAL MEMBER RESPONSIBILITIES WHILE USING NEMT SERVICES:

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at. www.hhs.gov/ocr

Complaint Process

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at (866) 449-6849 (TTY 711) to tell us about your problem. A Molina Member Services Advocate can help you file a complaint. Just call (866) 449-6849 (TTY 711). Most of the time, we can help you right away or at the most within a few days. Interpreter services are available at no cost.

Once you have gone through the Molina Healthcare complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services
Commission Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can send your complaint at: hhs.texas.gov/managed-care-help

Can someone from Molina help me file a complaint?

Yes, we want to help you with the complaint process. When you have a complaint, you can call Member Services and at (866) 449-6849 (TTY: 711) ask for help with your complaint.

How long will it take to process my complaint?

Your complaint will be handled within (30) calendar days from the date Molina receives your complaint. It could take less than 30 days. You will get a letter that tells you how your complaint was resolved. This letter will explain the complete complaint and appeal process. It will also tell you about your appeal rights. If the complaint is for an emergency for inpatient hospital or on-going care, Molina will resolve your complaint within one (1) business day.

What are the requirements and timeframes for filing a Complaint?

When we get your complaint, we will send you a letter within five days telling you we have your complaint. We will look into your complaint and decide the outcome. We will send you a letter telling you the outcome. We will not take more than 30 days to complete this process.

Appeal Process

How will I find out if services are denied?

If Molina denies your services, we will send you a letter.

What can I do if my doctor asks for a service or medicine for me that is covered but Molina denies it or limits it?

If you do not agree with Molina's decision to deny or limit your services, you can ask for an appeal. An appeal is when you or your representative asks Molina to look again at the services or medicines that we denied or limited.

If you ask someone to be your representative and to file an appeal for you, you must also send a letter to Molina to let us know you have chosen a person to represent you. We must have this information in writing for your privacy and security You can send the letter to:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P.O. Box 182273
Chattanooga, TN 37422

Can I continue getting the services that were already approved?

Yes, to keep getting the services that were approved but are now being denied or limited, you must file your appeal within 10 days from the day you get a letter telling you a service was denied or limited or from the date the services will end. If you ask to keep the services while your appeal is pending, you need to know that you may have to pay for these services.

What are the timeframes for the appeal process?

We will send you a letter within five (5) business days from when we get your request for an appeal. The letter will tell you that we got your appeal and we are working on it. We will make the final decision within 30 days after we get your appeal, unless we need more information from you or your representative. If we need more information, we may take up to 14 more days to complete your appeal. If we extend the appeals process, we will send you a letter. The letter will let you know the reason for the delay. You can also ask us to extend the process up to 14 days if you have more information that we should consider. Molina will send you and your doctor a letter with the final decision.

You can ask for an expedited appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. We will make our decision within 1 day after getting all of your information.

How soon do I need to ask for an appeal?

The appeal needs to be filed within 60 calendar days from the date on the letter telling you that all or part of your services were denied or limited.

Does my request have to be in writing?

You can request an appeal by telephone. You can call Member Services at (866) 449-6849 (TTY: 711) and someone can help you file your appeal.

You can also write your appeal and send it to:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P.O. Box 182273
Chattanooga, TN 37422

Can someone from Molina help me file an appeal?

Yes, someone in Member Services can help you file your appeal. Just ask for help when you call to file your appeal.

Can I ask for a State Fair Hearing and External Medical Review?

You can also request a State Fair Hearing and External Medical Review within 120 days afer Molina's appeal decision, unless you have asked for an expedited appeal. For more information, see the section on Expedited Appeals and State Fair Hearing/External Medical Review below.

Can I ask for only a State Fair Hearing?

Yes, you can also request for only a State Fair Hearing (without an External Medical Review) within 120 days after Molina's appeal decision. For more information, see the section on State Fair Hearings below.

Emergency Appeals

What is an emergency appeal?

An Emergency Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an emergency appeal? Does my request have to be in writing?

You can call Member Services and ask to file an emergency appeal. We will help you. You can ask for an expedited appeal by calling or in writing.

Who can help me in filing an emergency appeal?

You can call Member Services to file an emergency appeal. When you call, just tell them you would like to file an emergency appeal, they will know to work on it very quickly.

Toll free number: (866) 449-6849

If you send the emergency appeal in writing, send it to:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P.O. Box 182273
Chattanooga, TN 37422

What are the time frames for an emergency appeal?

Molina will make a decision within one (1) business day. For emergency appeals, we will send a letter telling you your appeal has been handled. We will send your provider a letter telling him/her that your appeal has been resolved.

What happens if Molina denies the request for an emergency appeal?

Molina may make a decision that your appeal should not be expedited. If this decision is made, we will follow the standard appeal process. As soon as this is decided, we will call you to let you know that the standard appeal process will be followed. We will also let you know by sending you a letter within 2 days from the date you asked for the expedited appeal.

Denied request for an emergency appeal
If you disagree with the decision, you have the right to request an expedited Fair Hearing from the State.

State Fair Hearing/External Medical Review

Can I ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 120 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to the health plan at:

Molina Healthcare of Texas
Attention Complaint & Appeal Dept.
P.O. Box 182273
Chattanooga, TN 37422

Or call Members Services Toll Free at: (866) 449-6849

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1)10 calendar days following the MCO's mailing of the notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an Emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain or regain maximum function, your or your representative may ask for an emergency State Fair hearing by writing or calling Molina. To qualify for an emergency State Fair Hearing through HHSC, you must first complete Molina's internal appeals process.

Can a Member ask for an External Medical Review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to as for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing occurs. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A proivder may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided an as attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Molina by using the address or fax number on the top of the form;
- Call the MCO at (866) 449-6849
- Email the MCO at TXMemberInquiryResearchAndResolution@MolinaHealthCare.Com

If the member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Reporting Abuse, Neglect, and Exploitation

How do I report suspected abuse, neglect, or exploitation?

You have the right to respect and dignity, including from Abuse, Neglect, and Exploitation.

What are Abuse, Neglect, and Exploitation?

Abuse is mental, emotional, physical or sexual injury, or failure to prevent such injury**.**

Neglect results in starvation, dehydration, overmedicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.

Exploitation is misusing the resources of another person for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting Abuse, Neglect, and Exploitation

The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 9-1-1 for life-threatening or emergency situations

Report by Phone (non-emergency): 24 hours a day, 7 days a week, toll-free

Report to the Department of Aging and Disability Services (DADS) by calling (800) 647-7418 if the person being abused, neglected, or exploited lives in or receives services from a:

- Nursing Facility;
- Assisted Living Facility;
- Adult Day Care Center;
- Licensed Adult Foster Care Provider; or
- Home and Community Support Services Agency (HCSSA or Home Health Agency

Suspected Abuse, Neglect, or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected abuse, neglect, or exploitation to DFPS by calling (800) 252-5400.

Reporting Electronically (non-emergency)
Go to https:txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful Information for Filing a Report

When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

Fraud and Abuse Information

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Molina Healthcare of Texas
Attention Compliance Officer
1660 N. Westridge Circle
Irving, Texas, 75038
1-866-606-3889

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

To report an issue online, visit: https://molinahealthcare.AlertLine.com

Information Available On a Yearly Basis

As a member of Molina you can ask for and get the following information each year:

- Information about network providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits.
- How you get after hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Molina's practice guidelines.

Your Privacy

Your Protected Health Information

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared. PHI means "protected health information." PHI is health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

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

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

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

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have 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 PHI on 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 and share PHI.
- 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 on our computers. PHI on our computers is kept private by using firewalls and passwords.

What must Molina do by law?

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

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

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

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

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. Our Notice of Privacy is included in Appendix A. It is also on our website at: MolinaHealthcare.com. You may get a copy of our Notice of Privacy Practices by calling Member Services toll free at: (866) 449-6849.

New Medical Procedures Review

As a member of the Molina health plan, one of your covered benefits includes the fact that we look at new medical advances, like new equipment, tests, and surgery. Each situation is looked at on a case-by-case basis, and sometimes we use a special review to make sure that it is right for you. For more information, call Member Services.

APPENDIX A: STAR+PLUS VALUE ADDED SERVICES

Efective September 1, 2023

24-hour Nurse Advice Line
Our nurses can answer your questions 24 hours a day, 7 days a week. Call (888) 275-8750 (English)/(866) 648-3537 (Spanish)
Up to $120 once a year: $30 Over-the-Counter Gift Card every three months
For over-the-counter medicines and other medical or health-related supplies not covered by Medicaid, upon request. Limited to currently enrolled non-dual Medicaid members. Cannot be used to buy food or water.
Emergency response services
For currently enrolled who are determined to be in need of the service. Service must be authorized by a Molina Service Coordinator. For currently enrolled STAR+PLUS non-Waiver Members age 21 and older and does not apply to Community First Choice members.
Adult Dental Services
Up to $250 per year for dental checkups, x-rays, and cleaning for Members age 21 and older. Must be enrolled at time of service.
Up to $40 each year: $20 gift card for members with major depression
For non-dual Medicaid members diagnosed with major depression and taking antidepressant medication, who stay on medication for 84 days. An extra $20 gift card for staying on medication for 180 days.
$30 Gift Card for having an office visit with a behavioral health specialist after hospitalization
For non-dual Medicaid Members who have an office visit with a behavioral health specialist within 7 days of hospitalization for a mental health condition. An extra $30 Gift Card for having an office visit within 30 days of hospitalization for a mental health condition. Must be verified.
One $20 Gift Card each year for getting a mammogram
For currently enrolled, non-dual Medicaid female Members ages 50 to 74 who get a recommended mammogram. Must be verified.
One $50 Gift Card for Cervical Cancer Screening
For currently enrolled non-dual Medicaid female Members ages 21 -64 who get a recommended cervical cancer screening once every three years. Must be verified.
$25 gift card for getting a Diabetic Eye Exam
For currently enrolled, non-dual diabetic Members who get a diabetic eye exam each year. Must be verified.
Four visits per year with a registered dietitian
For diabetic non-dual Medicaid members age 21 and older.
Up to $80 annually: $20 gift card for getting an HbA1c blood test every 6 months
For currently enrolled, diabetic Non-dual members. An extra $20 gift card for having an A1c less than 8. Lab testing and results must be verified.

$50 Academy gift card
For work-out clothes for non-dual Medicaid Members ages 16 and older who complete the Weight Watchers ® program.

Body weight scale
Available once a year for non-dual Medicaid Members with congestive heart failure.

Home-delivered meals
Up to 10 home-delivered meals each year after getting out of hospital or nursing facility for currently enrolled STAR+PLUS non- Waiver Members 21 and older. Must be authorized.

Home Visits
Up to an extra 8 hours respite services per calendar year for currently enrolled members that are unable to care for themselves due to absence of or need for relief for their unpaid caregiver. Service must be authorized by a Molina Service Coordinator. For STAR+PLUS non-Waiver Members ages 21 and older.

$100 eyewear allowance
Towards upgrades for frames, lenses, or contacts for members every two years. Limited to STAR+PLUS Non-Dual members.

One $75 gift card each year for refilling diabetic prescription
For currently enrolled non-dual Medicaid members who refill their diabetic prescription (medication) each month for six (6) months in a row. Must be verified.

One $50 gift card each year
For currently enrolled STAR+PLUS non-dual members with a diagnosis of high blood pressure who refill their high blood pressure prescription (medication) each month for six (6) months in a row. Must be verified.

Have questions? We're here to help. Call Member Services at (866) 449-6849, Monday to Friday, 8:00 a.m. – 6:00 p.m., central time. Tis call is free. Or visit MolinaHealthcare.com for more information.

APPENDIX B: MANAGED CARE TERMINOLOGY

Appeal - A request for your managed care organization to review a denial or a grievance again.

Complaint - A grievance that you communicate to your health insurer or plan.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Durable Medical Equipment (DME) - Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches, or diabetic supplies.

Emergency Medical Condition - An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency Medical Transportation - Ground or air ambulance services for an emergency medical condition.

Emergency Room Care - Emergency services you get in an emergency room.

Emergency Services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse

Excluded Services - Health care services that your health insurance or plan doesn't pay for or cover.

Grievance - A complaint to your health insurer or plan

Habilitation Services and Devices - Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance - A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.

Home Health Care - Health care services a person receives in a home.

Hospice Services - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

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

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

Medically Necessary - Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating Provider - A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

Participating Provider - A Provider who has a contract with your health insurer or plan to provide covered services to you.

Physician Services - Health-care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Plan - A benefit, like Medicaid, which provides and pays for your health-care services.

Pre-authorization - A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

Premium - The amount that must be paid for your health insurance or plan.

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

Prescription Drugs - Drugs and medications that by law require a prescription.

Primary Care Physician - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.

Primary Care Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.

Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.

Rehabilitation Services and Devices - Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

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

Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

APPENDIX C: NOTICE OF PRIVACY PRACTICES MOLINA HEALTHCARE OF TEXAS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Texas ("**Molina Healthcare," "Molina," "we"** or **"our"**) uses and shares protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private and to follow the terms of this Notice. The effective date of this Notice is September 23, 2013.

PHI stands for these words, protected health information. PHI means health information that includes your name, Member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

We use are share your PHI to provide you with health care benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill we would pay.

For Health Care Operations

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes, but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws
- Address Member needs, including solving complaints and grievances.

We will share your PHI with other companies (**"business associates"**) that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment, or other health-related benefits and services.

When can Molina use or share my PHI without getting written authorization (approval) from you?

The law allows or requires Molina to use and share PHI for several other purposes, including the following:

Required by law

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight

Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases.

Legal or Administrative Proceedings

Your PHI may be used or shared for legal proceedings, such as in response to a court order.

Law Enforcement

Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect, or Domestic Violence

Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures

Your PHI may be shared with funeral directors or coroners to help them do their jobs.

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 a purpose other than those listed in this Notice. Molina needs your authorization before we disclose your PHI for the following (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. Your cancellation will not apply toward actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

- **Request Restrictions on PHI Uses of Disclosures (Sharing of Your PHI)**
  You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request.

- **Request Confidential Communications of PHI**
  You may ask Molina to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use Molina's form to make your request.

- **Amend Your PHI**
  You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a Member. You will need to make this request in writing. You may use Molina's form to make your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that we give you a list of certain parties that we shared your PHI with during six years prior to the date of your request. The list will not include PHI shared as follows:
  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law**;**
  - PHI released in the interest of national security or for intelligence purposes; or
  - as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You will need to make your request in writing. You may use Molina's form to make your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Member Services Department at (866) 449-6849/ (877) 319-6828 – CHIP Rural Service Area (RSA).

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

You may complain to Molina and the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care and benefits will not change in any way.

You may file a complaint with us at:

Molina Healthcare of Texas
Manager of Member Services
1660 N. Westridge Cir.
Irving, TX 75038
Phone: (866) 449-6849/ (877) 319-6828 – CHIP Rural Service Area (RSA)

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office of Civil Rights
U.S. Department of Health & Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
(800) 368-1019; (800) 537-7697 (TDD);
(214) 767-0432 (FAX)

What are Molina's duties?

Molina is required to:

- Keep your PHI private;
- Give you written information such as this on our duties and privacy practices about your PHI;
- Provide you with a notice in the event any breach of your unsecured PHI;
- Not use or disclose your generic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is subject to Change.

Molina reserves the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, Molina will post the revised Notice on our website and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information

If you have any questions, please contact the following office:

Molina Healthcare of Texas
Attention: Manager of Member Services
84 N.E. Loop 410, Suite 200
San Antonio, TX 78216

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare of Texas
Medicaid

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

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

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

If you need these services, contact Molina Member Services at (866) 449-6849
TTY/TTD: (800) 346-4128.

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

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (713) 623-0645.

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

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

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

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

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-449-6849 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-449-6849 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-449-6849 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-449-6849（TTY：711）。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-449-6849 (TTY: 711) 번으로 전화해 주십시오.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-449-6849 (رقم هاتف الصم والبكم: 711).
Urdu	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-449-6849 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-449-6849 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-449-6849 (TTY : 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-449-6849 (TTY: 711) पर कॉल करें।
Persian (Farsi)	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-449-6849 (TTY: 711) تماس بگیرید.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-449-6849 (TTY: 711).
Gujarati	**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-866-449-6849 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-449-6849 (телетайп: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-866-449-6849（TTY：711）まで、お電話にてご連絡ください。
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-449-6849 (TTY: 711).