Welcome to Molina Healthcare.

Nevada (Medicaid and Nevada Check Up program)

MOLINA® HEALTHCARE

Non-Discrimination Notification
Molina Healthcare of Nevada
Medicaid

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin (including limited English proficiency), race, or sex. Discrimination on the basis of sex includes sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes.

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes: (1) Qualified interpreters (including qualified sign language interpreters). (2) Written Information in other formats, such as large print, audio, accessible electronic formats, and Braille.
- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes: (1) Qualified oral interpreters. (2) Information translated in your language.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Molina Member Services at 1-833-685-2102 or TTY/TDD: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at: molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit
200 Oceangate
Long Beach, CA 90802
Email: **civil.rights@molinahealthcare.com**
molinahealthcare.Alertline.com

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
TTY/TDD: 800-537-7697

Complaint forms are available here: hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

You can also send it to a website through the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf or call (800) 368-1019, TTY (800) 537-7697.

Distributed by Molina Healthcare of Nevada, Inc. (Molina). To get this information in other languages and accessible formats, please call Member Services. This number is on the back of your Member ID card. You can get this information free in formats like large print, braille, or audio. Call (833) 685-2102 (TTY/TDD: 711), Monday - Friday, 8 a.m. to 6 p.m., PT. Molina complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

Distribuido por Molina Healthcare of Nevada, Inc. (Molina). Para obtener esta información en otros idiomas y formatos accesibles, llame al Departamento de Servicios para Miembros. Este número telefónico se encuentra al reverso de su tarjeta de identificación del miembro. Puede solicitar esta información sin costo en otros formatos, como letra grande, sistema Braille o audio. Llame al (833) 685-2102 (TTY/TDD: 711), de lunes a viernes, de 8 a. m. a 6 p. m., hora del Pacífico. Molina cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Thank you for choosing Molina Healthcare!

Ever since our founder opened his first clinic in 1980, it has been our mission to provide quality health care to everyone. We are here for you. And today, as always, we treat our Members like family.

Molina Healthcare works with the Nevada Division of Welfare & Supportive Services (DWSS), and the Division of Healthcare Financing and Policy (DHCFP). We provide health services for the Nevada Medicaid and Nevada Check Up program. Along with your doctor, we help manage your care and health. Our job is to make sure you get the care and services you need. Please contact us if you have any questions.

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED AND INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN CONTRACTOR AND THE MEMBER

The most current version of the handbook is available at **MolinaHandbook.com/NV**

In this handbook you will find helpful information about:

Your Membership (pg 7)

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- Quick reference
- Phone numbers

Your Provider (pg 13)

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- Schedule your first visit
- Interpreter services

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- How to get specialty care & referrals
- Out-of-network provider
- What is an emergency?
- Post-stabilization
- Covered medications
- Access to behavioral health
- Mental health and/or substance abuse services
- Hospital services
- Payment & bills
- Nevada check up premiums
- Eligibility & enrollment/ Disenrollment
- Renewal of benefits
- Non-discrimination
- Grievance & appeals
- Member rights & responsibilities
- Advance directives
- Individual & institutional objection
- Fraud & Abuse
- Member privacy
- Member material terminology & definitions

NOTE: If you have any problem reading or understanding this or any Molina Healthcare information, call Member Services at (833) 685-2102 (TTY/TDD: 711). We can explain in English or in your primary language. We may have it printed in other languages. You may ask for it in braille, large print, or audio. If you are hearing or sight impaired, special help can be provided.

Health care is a journey and you are on the right path:

1. Review your Welcome Kit
Your Welcome Kit contains information about services and benefits available to you. For more information, get in touch with us.

2. Review your member ID card.
You should have received your Molina Healthcare ID card. Confirm that your information is correct. There is one for you and one for every member of your family enrolled with Molina. Please keep it with you at all times. If you haven't received your ID card yet, visit **MyMolina.com** or call Member Services at (833) 685-2102

3. Register for MyMolina
Signing up is easy. Visit **MyMolina.com** to change your Primary Care Provider (PCP), view service history, request a new ID card, opt in to receive text messages, and more. Connect from any device, anytime!

4. Talk about your health
Enclosed is a Health form for you to fill out for each member of your family covered by Medicaid or Nevada Check Up. It will help us identify how to give you the best possible care. Please let us know if your contact info has changed. Use the prepaid envelope enclosed to mail the forms back to us.

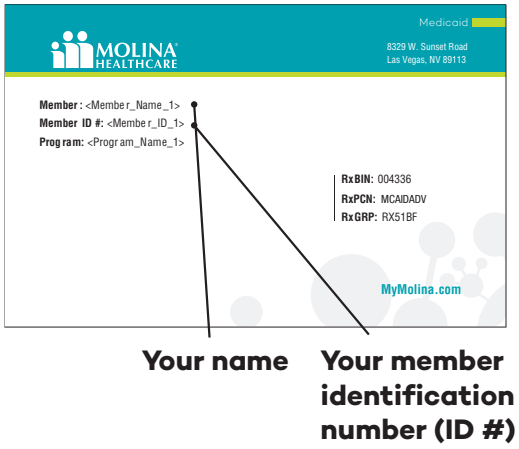
5. Get to know your PCP
PCP stands for Primary Care Provider. He or she will be your personal health care provider. To choose or change your PCP go to **MyMolina.com** or call Member Services at (833) 685-2102.

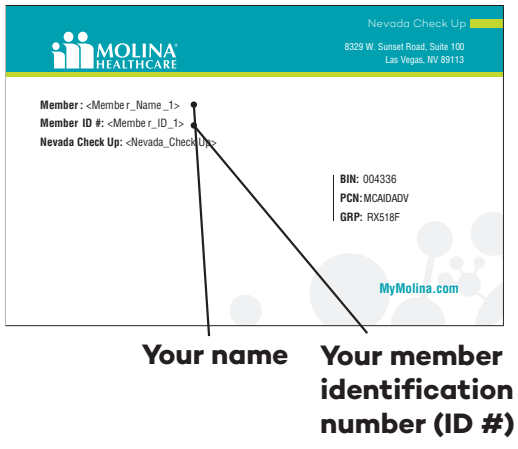
6. Get to know your benefits
With Molina you have health coverage and free extras. We offer free health education. And people dedicated to your care.

Your Membership

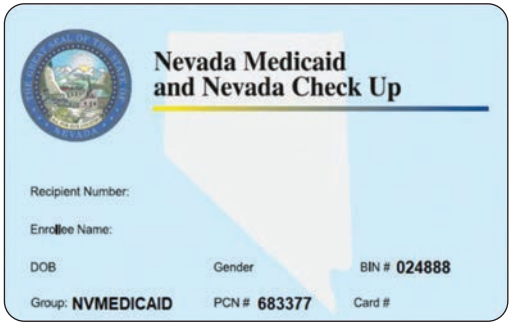
ID card

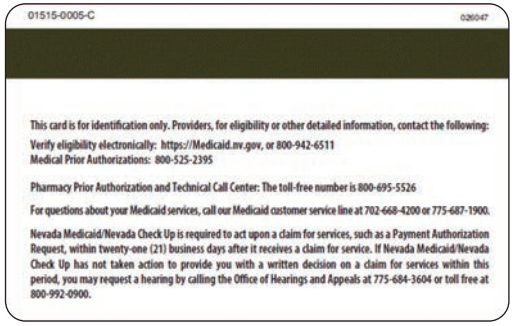
There is one ID card for each member.





The state will issue and mail you your Medicaid ID card.
Take it to your appointments along with your Molina ID card.





You need your Molina ID card to:

- See your provider, specialist or other provider
- Go to a hospital
- Go to an emergency room
- Get medical supplies and/or prescriptions
- Go to urgent care
- Have medical tests

Quick reference

Need

Emergency

- An emergency needs to be taken care of right away.
- You don't need approval for an emergency.
- Call 911 or go to an emergency room near you.

Online access

- Find or change your provider.
- Update your contact information.
- Request an ID card.
- Get health care reminders.
- Track office visits.
- Look up benefits and services.

Getting care

- Urgent Care.
  - Minor illnesses.
  - Minor injuries.
- Physicals and checkups.
- Preventive care.
- Immunizations (shots).
- Cold or flu symptoms.
- Wounds that may require stitches.
- Sprains, strains or deep bruises.
- Sore throat.
- Ear pain.
- Stomach flu.

Action

Call 911

If you think you have an emergency condition, call 911 or go to the nearest emergency room. An emergency includes:

- Major broken bones.
- Chest pain.
- Difficulty breathing.
- Excessive bleeding.
- Seizures or convulsions.

Go to **MyMolina.com** and sign up.

Find a provider at: **MolinaHealthcare.com/ProviderSearch**

Your plan details

- Questions about your plan.
- Questions about programs or services.
- ID card issues.
- Language services.
- Emergency transportation.
- Help with your visits.
- Prenatal care.
- Well visits with PCP or OB/GYN.

Changes/life events

- You moved.
- Change in name/address.
- You become pregnant.
- Marriage/divorce.
- You have a baby.
- Change your health coverage.

Call your doctor:

Name and Phone

24-hour Nurse Advice Line
(833) 685-2104
(TTY/TDD: 711)
A nurse is available 24 hours a day, 7 days a week.

Urgent care centers
Find a provider or urgent care center
MolinaHealthcare.com/ProviderSearch

Member Services
(833) 685-2102 (TTY/TDD: 711)
Monday - Friday
8 a.m.–6 p.m.
Non-emergency transportation services provided by MTM:

(844) 879-7341

Nevada Check Up members are not eligible for Non-emergency transportation services

Member Services
(833) 685-2102 (TTY/TDD: 711)
Nevada Division of Medicaid
(877) 638-3472
(Visually and hearing impaired dial **711**).

Your Primary Care Provider

Find your Primary Care Provider

Your Primary Care Provider (PCP) takes care of all your medical needs. Your PCP's office is your health home. It's important to have a PCP who makes you feel comfortable. It's easy to choose one with our Provider Directory, a list of providers. You can pick one for you and another for others in your family, or one who sees all of you. Schedule your first visit. Call your PCP right away if you need to cancel or reschedule your appointment. You can also call Molina Healthcare at (833) 685-2102 (TTY/TDD: 711) if you need help making an appointment, finding a provider, or finding information about your PCP.

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

If you wish to change your PCP, you can do this on your My Molina Mobile App, or from your desktop. You can also call Member Services at (833) 685-2102, Monday - Friday from 8 a.m.–6 p.m..

Schedule your first visit

Visit your Primary Care Provider (PCP) within 90 days of signing up. Learn more about your health and let your PCP know more about you.

Your Primary Care Provider will:

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

Interpreter services

If you need to speak in your own language, we can assist you. Call Member Services and we can assist you in your preferred language through an interpreter. An interpreter can help you talk to your provider, or pharmacist, or other medical service providers. We offer this service at no cost to you. An interpreter can help you:

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

If you need an interpreter, call the Member Services Department at (833) 685-2102. You can also ask your provider's staff to call the Member Services Department for you. They will help you get an interpreter to assist you during your appointment.

You must see a provider who is part of Molina.
If for any reason you want to change your primary provider, go to **MyMolina.com.** You can also call Member Services.

Remember, you can call the Nurse Advice Line at any time. Our nurses can help if you need urgent care. Call (833) 685-2104 (TTY/TDD: 711).

Benefits

Molina network

We have a growing family of health care providers and hospitals, and they are ready to serve you. Visit providers who are part of Molina. You can find a list of these providers at **MolinaHandbook.com/NV** (under Members-->Member Materials & Forms). Call Member Services if you need a printed copy of this list. You can also access the Molina Provider Directory on the Molina Mobile App or on the MyMolina web portal. These resources will also tell you if the provider has special hours, handicap accessibility and whether they can speak in your language.

The online directory contains provider information for all types of providers including PCPs, specialists, providers of ancillary services, as well as hospitals, behavioral health/substance use disorder facilities, and pharmacies in the Molina Nevada network. The information will include provider names and group affiliations, telephone numbers, street addresses, specialties and professional qualifications such as:

1. Provider's name as well as any group affiliation.
2. Street address(es).
3. Telephone number(s).
4. Website URL, as appropriate.
5. Whether the provider will accept new enrollees.
6. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
7. Whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam room(s) and equipment.
8. Identification of PCPs and PCP groups, specialists, hospitals, facilities, and federal qualified health centers (FQHCs) and rural health clinics (RHCs) by area of the state.

9. Identification of if a provider is accepting new patients or members (web-based version only).
10. Identification of hours of operation including identification of providers with non-traditional hours (before 8 a.m. or after 5 p.m. any weekend/holiday hours).

Call Member Services if you would like more detailed information about your provider such as:

- Name, address, telephone numbers.
- Professional qualifications.
- Specialty.
- Medical school attended.
- Board certification status.

For a full list of covered services, please refer to page 25. You may also request a copy of the Provider Directory.

Language services

If you have any problem reading or understanding this information or any other Molina Healthcare information, please contact Member Services at (833) 685-2102 (TTY/TDD: 711) for help at no cost to you. We can explain this information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing impaired, special help can be provided.

Translation Services

If you need to speak in your own language, we can help. A translator will be ready to talk to you. They can also help you talk to your provider. A translator can help you:

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

This is a free service. If you need a translator, call the Member Services Department (833) 685-2102, or (TTY/TDD: 711). If you are hearing or visually impaired, Molina can help you. You may ask for the member materials in braille, large print, or audio. All these services are free of charge.

Appointment guidelines

Your PCP's office should give you an appointment for the listed visits in this time frame:

PCP Visits	
Urgent care.	Same day.
Medically necessary PCP visit that is non-urgent or routine care.	2 days.
Well-child preventive care.	Within 14 days.
Adult preventive care.	Within 21 days.
Specialist.	Within 30 days of referral or if urgent within 3 calendar days.
Prenatal care visits*:	
First trimester.	Within seven (7) calendar days.
Second trimester.	Within seven (7) calendar days.
Third trimester.	Within three (3) calendar days.
High-risk pregnancy.	Within three (3) calendar days or sooner if needed.

*Same day. medically needed appointments are also available.

Your behavioral health office should give you an appointment for the listed visits in this time frame:

Appointment type	When you should get the appointment
Behavioral health/ substance use disorder providers (routine visit).	Not to exceed thirty (30) calendar days.
Behavioral health/ substance use disorder providers (urgent visit).	Not to exceed 3 calendar days.
Behavioral health life threatening emergency.	Immediately.
Follow up routine care visit.	14 days.

After-hours callbacks

We want you to be able to receive care at any time. When your PCP's office is closed, an answering service will take your call.

Pregnancy and newborn care

What if I have a baby?

Molina Healthcare wants to make sure you get medical care as soon as you think you are pregnant. If you think you are pregnant, see your PCP. Once you are pregnant your PCP will want you to see an OB/GYN. You don't need a referral to see an OB/GYN. It's important that you see your OB/GYN. If you need help finding an OB/GYN, call Member Services at (833) 685-2102 (TTY/TDD: 711); we can help you arrange for your prenatal care.

If you have a major life change, please call the Division of Welfare and Supportive Services at (800) 992-0900 or visit **AccessNevada.DWSS.NV.gov**.

Covered services

Prior approval process

You can get emergency care and most services without a prior approval. But some services do require a prior approval. For a prior approval request, a provider must contact your healthcare plan about the care they would like you to receive. Molina will review the request based on medical necessity and let your provider know if the request is approved before they can give you the service. This way, they can make sure it is appropriate for your specific condition.

For a list of covered services that do and do not require prior authorization, please refer to the Covered Services chart. You may also visit **MolinaHealthcare.com** or call Member Services.

If Molina does not cover the services you want or seek, because of moral or religious objections, you may call Nevada Medicaid or contact Member Services.

Covered services	Limitation
Ambulatory surgical center services.	Medically necessary surgeries, all Medicaid policy restrictions apply.
Behavioral health/ substance abuse disorder providers (post-discharge from an acute psychiatric hospital when the contractor is aware of the member's discharge not to exceed seven (7) calendar days.)	*All Medicaid policy restrictions apply.*

Covered services	Limitation and Description
Chiropractic services.	Limited to individuals under the age of 21 as referred through the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program and screened by their PCP.
Clinical trials	Routine patient costs associated with qualifying clinical trials.
Certified community behavioral health centers (CCBHC).	Provide care, referrals, and coordination of care. *All Medicaid Policy restrictions apply.*

Covered services	Limitation and Description
Dental services.	For children under 21 years of age, provided by Nevada Medicaid through Liberty Dental Plan. For adults, 21 years of age and older, Medicaid only covers emergency dental examinations and extractions, and in some instances false teeth (full and partial dentures to replace missing teeth). Contact Liberty Dental Plan at: (888) 700-0643.
Diabetic lab work and retinal eye screening.	Annually.
Dialysis.	Freestanding or hospital-based center services.
Durable medical equipment.	*All Medicaid policy restrictions apply.*
Emergency ambulance services.	Medically necessary ambulance service is covered. Excludes: Non-emergency medical transportation.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.	Limited to beneficiaries under 21 years of age.
ER visits.	No limit.
Eye care - vision services.	One exam every 12 months. All members, lenses and frames every 12 months.
Family planning services.	Unlimited, no referral needed. Members can receive family planning services at no cost from plan or non-plan providers.
Gender Reassignment Services	Treatment of gender dysphoria and gender incongruence, based on medical necessity. All Medicaid policy restrictions apply.
Hearing services.	• Hearing aid(s) and related supplies. • Hearing aid testing and repairs. • Replacement of lost or damaged ear mold(s) only for those under 21. • Hearing aids and related supplies are limited to once every 24 months.

Covered services	Limitation and Description
Home health services.	• Same day for Members with urgent needs. • Prior authorization required. • Limitations apply. • Non-urgent care within fourteen (14) calendar days.
Hospital services.	Inpatient and outpatient.
Hysterectomy.	Consent for Sterilization (form HHS-687) required.
Laboratory services.	*All Medicaid policy restrictions apply. No prior authorization are required for emergencies.*
Mammogram/pap smears.	No prior authorization required.
Medical supplies.	*All Medicaid policy restrictions apply.*
OB/GYN and nurse midwife services.	Including prenatal and postpartum visits.
Physician office services, physician assistant office visits and nurse practitioner office visits.	No limit.

Covered services	Limitation and Description
Podiatrist services.	Podiatry Services for adults are covered with a prior authorization, limitations apply. Foot care is covered for children under 21. Foot care visits may be limited. Orthotics are covered for some conditions.
Prenatal care-maternity services.	Including postpartum care.
Preventative care.	Mammograms, well baby and well child care, regular check-ups, EPSDT services.
Radiology/X-rays.	*Medically necessary ordered by a doctor. All Medicaid policy restrictions apply.*
Specialty injection/infusion.	Injections are covered for certain spastic conditions including cerebral palsy, stroke, head trauma, spinal cord injuries and multiple sclerosis.
Sterilization procedures.	Requires consent forms.
Substance abuse services.	Inpatient/outpatient care.

Covered services	Limitation and Description
Transplants.	For children under 21 years of age, any medically necessary transplant that is not experimental will be covered. For adults, corneal, kidney, liver and bone marrow transplants will be covered if medically necessary with limitations.
Vaccines.	EPSDT immunizations, flu shots, COVID-19 shots, and pneumonia vaccines. ACIP recommended vaccines for adults. For a list of vaccine recommendations and guidelines, visit: **cdc.gov/vaccines/hcp/acip-recs/index.html**

In Lieu of Services (ILOS)

ILOS are services or settings that Medicaid plans may offer in place of services or settings covered under the Nevada Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. ILOS are optional for members to utilize. ILOS are designed to substitute for and potentially decrease utilization of other covered Medicaid benefits, such as hospital care, nursing facility care, and Emergency Department (ED) use while improving quality of life.

Nevada Medicaid has added new benefits as ILOS for its managed care program that are critical to addressing homelessness, improving outcomes, and lowering costs. Molina will offer:

- **Short-Term Housing & Transition Supports to support** Medicaid recipients without a residence who have high medical or behavioral health needs with continuing their care or treatment as they transition into the community from an inpatient, correctional, or institutional/residential setting.

Eligibility for In Lieu of Services

To be determined eligible for the new housing supports benefit as ILOS in Nevada's Medicaid managed care program, the Medicaid recipient must be: (1) experiencing homelessness; or (2) at risk of experiencing homelessness as defined under 24 CFR 91.5 and have at least one or more of the following conditions or circumstances described below:

1. Has a Serious Mental Illness (SMI) designation or is in need of behavioral health services and/or substance use treatment;
2. Is at high risk of repeated avoidable emergency department visits or crisis utilization;
3. Is pregnant or has delivered a live birth within the last 60 days;

4. Has a chronic health condition and/or co-occurring conditions;
5. Is at high risk of homelessness due to being discharged from a correctional or medical facility;
6. Is at high risk of institutionalization without housing supports; or
7. Is transitioning from an institutional setting to a home- or community-based setting and is at high risk of homelessness without housing supports.

Molina can: (1) utilize their case management teams; or (2) other qualified providers under contract with the MCO to screen and assess members to determine eligibility for the new ILOS housing supports. When utilizing Molina's case management team, a referral for ILOS housing supports to a qualified housing supports provider must be signed by a licensed case manager and determined to be medically necessary and cost effective as defined by the MCO and approved under ILOS guidelines. For referrals from other contracted providers, a prior authorization request must be sent to the MCO for review and approval by a licensed case manager and determined to be medically necessary and cost effective as defined by the MCO and under ILOS guidelines.

You will be informed of changes to programs and benefits within 30 calendar days prior to implementation.

Services not covered

Molina Healthcare will not pay for services received outside of the U.S. Molina Healthcare will not pay for services or supplies received without following the directions in this handbook. Some examples of non-covered services include:

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

This is not a complete list of the services that are not covered by Medicaid or Molina Healthcare. If you have a question about whether a service is covered, please call Member Services.

Services covered by Nevada Medicaid

Some services are covered by Nevada Check Up or Medicaid instead of Molina. You do not need a referral for these services. These are called carved-out services and include:

- Adult day health care.
- Children in out-of-home placement.
- Home and community-based waiver services.*
- Hospice.*
- Indian health service facilities and tribal clinics.
- Intermediate care facilities for members with intellectual disabilities.*
- Non-emergency transportation (only available to Medicaid members).**

- Nursing facility stays longer than one hundred eighty (180) calendar days.
- Evaluations/screening for appropriate level of care before admission to a facility residential treatment center for Medicaid members.*
- School health services (Molina covers when provided by federally qualified health centers or rural health clinics).
- Treatment for severe emotional disturbance/ serious mental illness.

If you have questions about how to obtain these services, please contact Molina Member Services at (833) 685-2102 (TTY: 711), Monday through Friday from 8 a.m. to 6 p.m. We can help you.

*Members who receive these services will be disenrolled from Molina and will receive health care benefits directly from fee-for-service Medicaid.

**Non-emergency transportation is available for Medicaid recipients through the state's transportation vendor, MTM. Non-emergency transportation is not available to Nevada Check Up recipients.

Molina Healthcare must provide all medically necessary services for its members who are under age 21. This is the law. This is true even if Molina Healthcare does not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limit.
- No time limits, like hourly or daily limits.

Your provider may need to ask Molina Healthcare for approval before giving your child the service. Call Member Services if you want to know how to ask for these services.

Early and Periodic Screening Diagnosis and Treatment services (EPSDT)

All children and adolescents under the age of twenty-one (21) who are Molina members are eligible to receive Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT). These services are provided without limitation, at no cost if deemed medically necessary.

Covered EPSDT services

Services include periodic health screenings and appropriate up-to-date immunizations using the recommended immunization schedule provided by the Advisory Committee on Immunization Practices (ACIP). The EPSDT also include examinations for vision, dental, hearing and all medically necessary services.

Periodic health screening:

- A comprehensive unclothed physical exam.
- Comprehensive beneficiary and family/medical history.
- Developmental history.
- Measurements, including, but not limited to length/ height, weight, head circumference. body mass index (BMI) and blood pressure.
- Vision and hearing screenings.
- Developmental/behavioral assessment.

- Autism screening.
- Developmental surveillance.
- Psychosocial/behavioral assessment.
- Tobacco, alcohol and drug use assessment.
- Depression screening.
- Maternal depression screening.
- Newborn metabolic/hemoglobin screening.
- Vaccine administration, if indicated.
- Anemia screening.
- Lead screening and testing.
- Tuberculin test, if indicated.
- Dyslipidemia screening.
- Sexually transmitted infection.
- HIV testing.
- Cervical dysplasia screening.
- Dental assessment and counseling.
- Anticipatory guidance.
- Nutritional assessment.
- Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC) status.

Periodicity schedule:

Frequency is as follows:

- 3-5 days.
- By one month.
- Two months.
- Four months.
- Six months.
- Nine months.
- 12 months.
- 15 months.
- 18 months.
- 24 months.
- 30 months.
- Once a year for ages 3-21 years old.

If you need help accessing EPSDT services for your child, please call Member Services (833) 685-2102 (TTY/TDD: 711).

Expanded EPSDT services for eligible members that are found during an EPSDT exam and are deemed medically necessary include:

- Adolescent counseling services.
- Therapy services (physical, occupational, speech, hearing and language).
- Additional treatments and services that may be needed (such as prescriptions and therapy services).
- Prescription drugs.
- Inpatient hospital.
- Outpatient hospital services.
- Home health services.
- Private duty nursing.
- Durable medical equipment/prosthetics.
- Dental services.
- Optometry services.
- Eyeglass/contacts.
- Hearing services.

- Mental health services.
- Podiatry services.
- Chiropratic services.

Second opinions
If you do not agree with your provider's plan of care for you, you have the right to a second opinion. Talk to another provider or out-of-network provider. This service is at no cost to you. Call Member Services to learn how to get a second opinion.

Vision

We are here to take care of the whole you, including your eyes. Molina, through VSP Vision, covers eye exams every year for all members.

- Eyewear (frames and lenses) every year, when requirements are met.
- Medically necessary eye care services, including treatment of eye conditions.
- Frame repair or replacement of eyeglasses once per year to members of all ages (restrictions may apply).
- Other services as outlined in the Nevada Department of Health and Human Services Medicaid Manual: **dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/**.
- Additional $100 above the standard benefit for medically necessary and appropriate services (such as corrective lenses or contacts) every 24 months for members 21 years or older.

Please contact Molina Healthcare's Member Services Department with any questions regarding your vision benefits at (833) 685-2102 (TTY/TDD: 711).

Please check your Molina Healthcare Provider Directory to find optometrists or physicians who can provide you with these services at **MyMolina.com.**

Covered medications

Molina Healthcare covers all medications listed on the Nevada Division of Medicaid Preferred Drug List (PDL). These are drugs we prefer your Primary Care Provider prescribe.

Most generic drugs are included in the list. You can find a list of preferred drugs on our **Preferred Drug List**

There are also drugs that are not covered. For example, drugs for erectile dysfunction, weight loss, cosmetic purposes and infertility are not covered.

We are on your side. We will work with your provider to decide which drugs are the best for you.

Your Extras

MyMolina.com: Manage your health plan online

Connect to our secure portal from any device, wherever you are. Change your provider, update your contact info, request a new ID card and much more. To sign up, visit **MyMolina.com.**

Molina Mobile App:

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

- View your member ID card.
- Find a provider or facility near you with the Provider Finder.
- Use the Nurse Advice Line to get the care you need.
- Access your medical records.

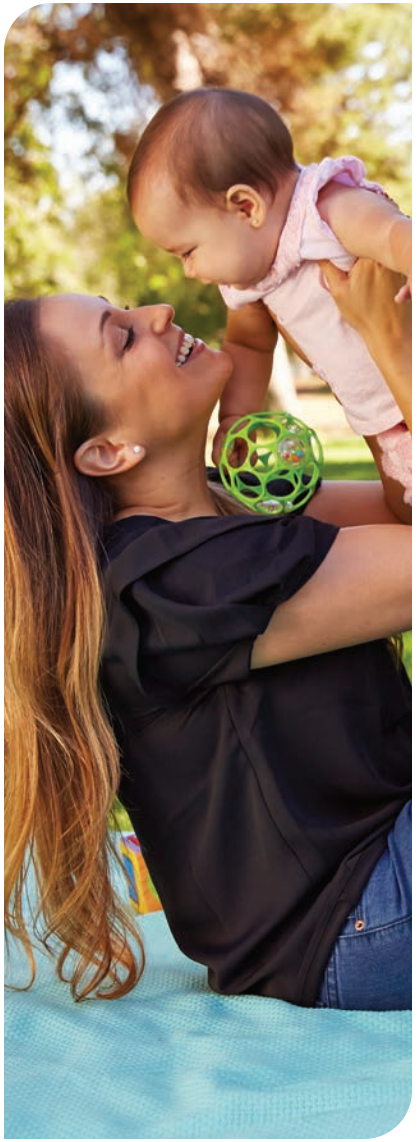
You can download the app for free on your smartphone using the app store for Apple and Google Play for Android.

Health education and incentives programs

Live well and stay healthy! Our free programs help you control your weight, stop smoking or get help with chronic conditions. You get learning materials, care tips and more. We also have programs for expectant mothers. If you have asthma, diabetes, heart problems or any other chronic conditions, one of our nurses or case managers will contact you. You can also sign up on **MyMolina.com**, our secure Member portal, or call the Health Management departments at:

Weight management, stop smoking and other programs: (866) 472-9483 (TTY/TDD: 711).

Chronic conditions: (866) 891-2320 (TTY/TDD: 711).



Healthy rewards for pregnant moms

Are you going to have a baby? Molina Healthcare wants you to have a healthy pregnancy and baby. You could earn gift rewards with our pregnancy rewards program! It is easy. Sign up at **MyMolina.com**, our secure portal.

Transportation

Lean on Molina for enhanced transportation benefits, like rides to food banks, WIC appointments, job interviews, housing agencies, and domestic violence agencies. DMV, Medicaid office and more.

Non-emergency medical transportation is available through MTM. They arrange rides to covered services for members who have no other way to receive a ride to their routine medical appointments. If you qualify for this service and need to arrange non-emergency transportation, contact MTM at (844) 879-7341 (TTY/TDD: 711).

Non-emergency transportation is not available to Nevada Check Up members.

Call to schedule your ride. You must give at least five working days' notice when scheduling transportation.

Case management

We have a team of nurses and social workers ready to serve you. They are called case managers. They are very helpful. They will give you extra attention if you have:

- Asthma.
- Behavioral health disorders.
- Chronic obstructive pulmonary disease (COPD).
- Diabetes.
- High blood pressure.
- High-risk pregnancy.
- Obesity.
- Heart failure.
- Organ transplant.
- Members discharged from the hospital.
- Other chronic health conditions.

Any Molina member may ask for a case manager to assist them with their health care needs.

Call Member Services at (833) 685-2102 to request a case manager.

Community resources

We are part of your community. And we work hard to make it healthier. Local resources, health events and community organizations are available to you. They provide great programs and convenient services. Best of all, most of them are free or at low cost to you.

- **MolinaHelpFinder.com** powered by Aunt Bertha. This is a free and confidential service that will help you find local resources. Available 24/7.
- Women, Infants and Children's Nutrition Program (WIC) (800) 863-8942.

To request value-added benefits visit the member portal, **MyMolina.com** or contact the Wellness Rewards Contact Center **(833) 685-2117**.
Healthy Rewards for members are now available on a reloadable card. That means one card for all your Healthy Rewards. You can use your card in stores, online, at the gas pump and more!

Program	Member action	Eligible populations	Amount/ Service caps
Annual baby shower.	Attend a Molina baby shower.	Members who are currently pregnant.	$100 gift card/ incentive (member only). May bring two guests.
Sam's Club membership.	Call the Wellness Rewards Contact Center.	18 years and older.	One free Sam's Club membership per family.
Electronic breast pump.	Call the Wellness Rewards Contact Center.	New moms.	One per member.
Healthy rewards.	Complete a well-child visit annually.	3-20 years old.	$100 per year.
	Complete annual adult preventive screening visit (limited to one per year).	18 years and older.	$75 gift card.
	Complete one postpartum visit 7-84 days after the birth of the baby.	New moms.	$75 per visit gift card.
	Complete a prenatal visit during their first trimester or within 42 days of enrollment.	Pregnant women.	Free or booster seat.
	Complete a yearly diabetic retinal eye exam and complete HbA1c lab work.	18 - 75 years old, diagnosed with diabetes.	$50 gift card each ($100 max annually).
	Complete an annual mammogram screening.	50-74 years old (female).	$25 gift card. Limited to one per member, per year.

Program	Member action	Eligible populations	Amount/ Service caps
Healthy rewards. (Cond.)	Complete up to six well-child visits on time within a 15-month period.	0-15 months old.	$10/visit (max $60 gift card).
	Complete two child visits when the child is between 15-30 months old.	15-30 months old.	$75 gift card.
	Complete an annual office visit for cervical cancer screening (pap test).	21-64 years old (female).	$25 gift card.
	Complete an annual chlamydia screening. Requires member attestation, provider attestation or claim.	16-24 years old (female).	$25 gift card.
	Complete an annual syphilis screening and treatment prior to giving birth. Requires member attestation, provider attestation or claim.	16-24 years old (female).	$25 gift card.
	Complete a follow-up visit with a behavioral health provider within seven days of an inpatient hospitalization for mental illness.	All members.	$50 gift card. (one per month with max $600)
	Complete a follow-up visit within 7 days of an Emergency Department Visit for Behavioral Health Crisis or Condition	Members age 6 and up.	$50 gift card (one per month with annual max of $600)
	Complete a follow-up visit within 7 days of the Emergency Department visit for Substance Use Disorder or unintentional overdose	Members age 13 and up.	$50 gift card (one per month with annual max of $600)

Program	Member action	Eligible populations	Amount/ Service caps
Healthmap Assessment: Healthmap offers a personalized Kidney Health Management (KHM) program designed to maintain and improve your health. Our Care Navigation team works with you and your doctor to help meet your health goals.	Complete the Healthmap Assessment. Call (800) 819-5175, to get started in the KHM program. Learn more at **patients.healthmapsolutions.com**.	Members who complete the Healthmap Assessment.	$15 gift card (effective June 2023).
Mom's Meals: Members may request home delivered meals to support nutritional needs during pregnancy and postpartum.	Contact the Wellness Rewards Center	Members who are pregnant or through the first year postpartum.	$7 per meal at 3X a day for one week ($147).

Program	Member action	Eligible populations	Amount/ Service caps
Genetic Testing Program: we cover certain genetic tests that are needed to determine the most effective course of care for oncology treatment.	Request a genetic test from your provider.	Members requiring oncology treatment.	One per member.
School/ sports physical.	Schedule an appointment with your provider.	6-18 years old.	Free annual physical per year.
Vision: Additional $100 above the standard benefit for medically necessary and appropriate services (such as corrective lenses or contacts) every 24 months.	To learn more, visit **VSP.com/medicaid**	21 years and older.	$100.

Program	Member action	Eligible populations	Amount/ Service caps
Obesity/Weight Watchers: members will receive up to 13 weeks of digital Weight Watchers (WW) services. Kurbo by WW targeted to children 8-18 years old.	Call the Wellness Rewards Contact Center to request a code. To learn more, visit **WeightWatchers.com**	All members.	$45 value ($3.30 per week/digital).
Replace lost ID card or birth certificate.	Call the Wellness Rewards Contact Center.	Medicaid Members.	Varies based on household.
Asthma: receive an allergy-free pillowcase and mattress cover. For children under 18 who have been prescribed an inhaler, Molina will provide a second inhaler at no additional cost.	Members who complete a health education call. Contact the Wellness Rewards Center.	Mattress/Pillow: All members in the Asthma Disease Management program Second inhaler: 2-18 years old.	Mattress cover: $60. Second inhaler: no cost for member. Pillow covers: $20.

Program	Member action	Eligible populations	Amount/ Service caps
Over the counter medication – including pregnancy tests.	To learn more, visit **NationsOTC.com/ MolinaNV**	All members.	$30 per member household, per quarter for commonly used OTC items through our mail order program.
Bus passes to certain social services, including food banks, WIC offices, Medicaid offices, DMV, domestic violence agencies, the housing authority, and job interviews. You may bring up to two family members.	Call the Wellness Rewards Contact Center.	All members.	Provides transportation to non-medical appointments. Only two additional family members. Limited to one round trip per month.

Program	Member action	Eligible populations	Amount/ Service caps
Boys and Girls Club: free Boys and Girls Club membership for the after-school program for ages 6-18.	Contact your local Boys and Girls Club.	We will provide youth-organization membership dues to the Boys & Girls Club program, for qualified members under the age of 19.	$20-$35 per child (depends on the individual club).
GED.	Must pass GED tests and receive certificate. Call the Wellness Rewards Contact Center.	18 years and older.	Vouchers to take GED tests for free at authorized testing centers. $50 gift card after passing the tests.
Alternatives to opioids.	Call the Wellness Rewards Contact Center.	Members ages 21+ with chronic pain.	Adult members can receive up to $150 for massage therapy.

Program	Member action	Eligible populations	Amount/ Service caps
Molina Help Finder powered by Aunt Bertha community services directory and referral system: provides members on demand, 24/7 access from our website and mobile application access to thousands of community resources across the state in the areas of health, financial support, education, emergency resources, legal support, housing, employment opportunities, transportation, and food security.	Visit **MolinaHelpFinder.com** Scan to learn more about: **MolinaHealthcare.com/NV/BenefitsandRewards**	All members.	Free – no cost for member.

All rewards and enhanced services may have exclusions or limits. Members must have Molina Healthcare of Nevada Medicaid or Nevada Check Up as their primary insurance at the time of service to qualify for Rewards and Enhanced Services. Rewards and Enhanced Services must be claimed within 90 days after the services are received.

You matter to Molina, and so do your thoughts. Share your opinions and earn rewards! You can also recommend changes to Molina policies and services. Become an advisor and earn a $15 gas or grocery store gift card

Contact **NV_GCE_Team@MolinaHealthcare.com** for information on how to attend.

You may also call Member Services (833) 685-2102 to tell us your ideas.

Your Policy

How to choose a Primary Care Provider (PCP)

It is easy to choose a Primary Care Provider (or PCP). Use our Provider Directory to select from a list of providers. You may want to choose one provider who will see your whole family. Alternatively, you may want to choose one provider for you and another one for your family members.

Your PCP knows you well and takes care of all your medical needs. Choose a PCP as soon as you can. It is important that you feel comfortable with the PCP you choose.

In addition to your PCP, female members can obtain women's preventive health services from a women's health provider without prior authorization. You do not need a referral from your PCP. Members with disabilities have an additional 30 calendar days to select a PCP.

Call and schedule your first visit to get to know your PCP. If you need help making an appointment, call Molina Healthcare toll-free at (833) 685-2102 (TTY/TDD: 711). Molina Healthcare can also help you find a PCP. Tell us what is important to you in choosing a PCP. We are happy to help you. Call Member Services if you want more information.

You will be informed of changes to the provider network within 15 days after Molina receives notification.

How to get specialty care and referrals

If you need care that your PCP cannot give, he or she will refer you to a specialist who can. Talk with your PCP to be sure you know how referrals work. If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask Molina Healthcare to approve before you can get them. That is called a "pre-authorization." Your PCP will be able to tell you what services require this approval.

For members with special healthcare needs determined through an assessment to need a course of treatment or regular care monitoring, Molina allows members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the condition and identified needs.

If we do not have a specialist in Molina Healthcare who can give you the care you need, we will get you the care you need from a specialist outside Molina Healthcare. Getting a referral from your PCP ensures your health care is coordinated and all your providers know your health care goals and plans.

For members requesting care from a specialist outside the network, your PCP or the specialist you are seeing needs to request prior approval of specialty care or services from Molina Healthcare via fax or phone call. This request for prior approval must be done before any treatments or tests take place. If a request for specialty care is denied by Molina Healthcare, we will send you and the requesting provider a letter. You or your PCP can appeal our decision. If your PCP or Molina Healthcare refers you to a provider outside our network, you are not responsible for any of the costs. Molina Healthcare will pay for these services.

If you need to see a provider that is not part of Molina

If a Molina Healthcare provider is unable to provide you with necessary and covered services, Molina Healthcare must cover the needed services through an out-of-network provider. This must be done in a timely manner for as long as Molina's provider network is unable to provide the service.

What is an emergency?

An emergency needs to be taken care of right away. You don't need approval for an emergency visit. Call 911 or go to an emergency room near you. You can go to any emergency room or other facility that is not part of Molina's network. You can get care (24) hours a day, (7) days a week. If you have an emergency medical condition you are not responsible for payment of screening and treatment needed to diagnose your condition or stabilize you. The emergency room doctor treating you will decide when you can be transferred or discharged. If the emergency room provider says that you don't have to stay but you still stay, you may have to pay.

You might need care after you leave the ER. If you do, don't go to the ER for follow up care. If you need help seeing a provider, call Member Services. If you don't have an emergency, don't go to the ER.
Call your PCP.

Molina Healthcare has a 24-Hour Nurse Advice Line which can also help you understand and get the medical care you need. If you need non-emergent care after normal business hours, you can also visit an urgent care center. You can find urgent care centers in the provider directory. If you need help finding one you can call Member Services at (833) 685-2102 (TTY/TDD: 711). You may also visit our website at **MolinaHealthcare.com/NV**.

What is post-stabilization?
These are services you get after ER care. These services keep your condition stable. You do not need approval for these services. After your visit to the ER, you should call your provider as soon as you can. Your provider will help you get any follow-up

care you need. A prior authorization is required if the services are provided by an out-of-network provider. You can also call Member Services for help.

When does payment for unauthorized post-stabilization services end?

When

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes responsibility for the member's care through transfer.
- An organization representative and the treating physician reach an agreement concerning the member's care.
- The member is discharged

Covered medications

To be sure you are getting the care you need, we may require your provider to submit a request to us- a prior authorization (PA). Your provider will need to explain why you need a certain drug or a certain amount of a drug. We must approve the Prior Authorization request before you can get the medication. Reasons why we may require Prior Authorization of a drug include:

- There is a generic.
- There may be another preferred drug available.
- The drug can be misused or abused.
- The drug is listed in the formulary but not found on the preferred drug list (PDL).
- There are other drugs that must be tried first.

Some drugs may also have quantity (amount) limits and some drugs are never covered. Some drugs that are never covered are:

- Drugs for weight loss.
- Drugs for erectile dysfunction.
- Drugs for infertility.

If we do not approve a Prior Authorization request for a drug, we will send you and your provider a letter. The letter will explain how to appeal our decision. It will also detail your rights to a State Fair Hearing.

Remember to fill your prescriptions before you travel out of state.

A preferred drug list (PDL) is a list of drugs Molina prefers your doctor prescribe.

The PDL can change. It is important for you and your provider to check the Nevada Division of Medicaid's Universal Preferred Drug List (PDL) when you need to fill or refill a medication. You can find a link to the Nevada Division of Medicaid's Universal PDL at **MolinaHealthcare.com/NV.** You can find a Medicaid pharmacy provider by visiting our website at **MolinaProviderDirectory.com/NV/Medicaid** or calling Member Services.

Access to behavioral health

If you are referred for a serious mental health (SMI) assessment or are the parent/guardian of a minor member who is referred for serious emotional disturbance (SED) assessment, your provider will fully inform you of the reason why the assessment is necessary. If the member is a minor, authorization to conduct the assessments must be obtained from the member's parent/guardian.

Molina can help you get the behavioral health services you and your family need. You must use a provider that is part of our behavioral health network, unless it's an emergency. Your benefits cover inpatient services, outpatient services, and provider visits. You don't need a referral to see a provider. You can pick or change your behavioral health care provider or care manager at any time.

They can help you get the services you need and provide a list of covered services.

What to do if you are having a problem

You might be having these feelings:

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

If so, call Molina at (833) 685-2102 (TTY/TDD: 711).

Emergency behavioral health services

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

If you have an emergency, go to the closest hospital emergency room. You can go to any other emergency place right away. You can call 911. If you go to the ER, let your provider know as soon as you can.

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

- Go to the closest hospital or facility.
- Call the number on your ID card.
- Call your provider and follow-up within (24) to (48) hours.

For out-of-area emergency care, the plan will transfer you to a provider that is part of an approved behavioral health provider group or network. We will only do this when you are well.

If you are referred for a serious mental health (SMI) assessment or are the parent/guardian of a minor member who is referred for serious emotional disturbance (SED) assessment, your provider will fully inform you of the reason why the assessment is necessary. If the member is a minor, authorization to conduct the assessments must be obtained from the member's parent/guardian.

Mental health and/or substance abuse services

If you need the mental health and/or substance abuse services, call the Nurse Advice Line for information at (833) 685-2104 (TTY/TDD: 711) for the hearing impaired: or you may self-refer directly to a state certified community mental health center or treatment center. You can also look at the provider directory online at **MolinaHealthcare.com**, visit member portal at **MyMolina.com** or call Member Services for the names and telephone numbers of the facilities near you.

How to access hospital services

Inpatient hospital services

You must have a prior authorization to get hospital services except in the case of an emergency or urgent care services. Please use the Provider Directory to see the addresses of all emergency rooms and urgent care facilities. You can do this with the My Molina Mobile App or on your desktop. You can also request a printed version of the directory by calling Member Services. However, if you get services in a hospital or you are admitted to the hospital for emergency or out-of-area urgent care services, your hospital stay will be covered. This happens even if you do not have a prior authorization.

Medical/surgical services

We cover the following inpatient services in a participating provider hospital or rehabilitation facility, when the services are generally and customarily provided by acute care general hospitals or rehabilitation facilities inside our service area:

- Room and board, including a private room if medically necessary.
- Specialized care and critical care units.
- General and special nursing care.
- Operating and recovery rooms.
- Services of participating provider physicians, including consultation and treatment by specialists.
- Anesthesia.
- Drugs prescribed in accord with the Universal Preferred Drug guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Prescription Drugs and Medications").

- Radioactive materials used for therapeutic purposes.
- Durable medical equipment and medical supplies.
- Imagining, laboratory, and special procedures, including MRI, CT, and PET scans, and ultrasound imaging.
- Mastectomies (removal of breast) and lymph node dissections.
- Blood, blood products and their administration, blood storage (including the services and supplies of a blood bank).
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program).
- Respiratory therapy.
- Medical social services and discharge planning.

How does Molina pay providers for your care?

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

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

Payment and bills

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

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

Nevada check up premiums

A premium is a quarterly payment you pay for health care coverage for your child. Only Nevada Check Up members have premiums. Native Americans and Alaska Natives don't pay premiums.

Remember, if you have a quarterly premium and do not pay it, your child will be disenrolled. This

premium will go toward your family cost-share. Your family cost-share is based on your total family income. To find out more about premiums, call the Nevada Check Up program at (775) 684-3777, or toll-free at (800) 992-0900. You can also go to the Division of Health Care Financing and Policy website at **dhcfp.nv.gov/Pgms/CPT/NevadaCheckUp/NCUMAIN/**.

Looking at what's new

We look at new types of services, and we look at new ways to provide those services. We review new studies to see if new services are proven to be safe for possible added benefits. Molina Healthcare reviews the type of services listed below at least once a year:

- Medical services.
- Mental health services.
- Medicines.
- Equipment.

Eligibility and enrollment

Please call the Nevada Division of Welfare and Supportive Services about eligibility. They are open Monday through Friday from 8 a.m. - 5 p.m. Their number is (800) 992-0900 (TTY:711).

Enrollment period

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled with Molina Healthcare or the state enrolls you in a plan, you can change plans within the first 90 days from the date of enrollment with the plan. After the 90 days, if you are still eligible for Medicaid, you may be enrolled in the plan for the next nine months. This is called "lock-in".

Open enrollment

Every year the state will hold an open enrollment period. Open enrollment allows members the option to switch plans.

If you switch plans during open enrollment it will be effective January 1 of the following year. Any member who switched plans during open enrollment will have the option to choose another plan in the first 90 days if they are not satisfied.

You do not have to change health plans. Once your final selection is made, you will be locked into that health plan until the next open enrollment period.

Disenrollment

Members may change their plan selection:

- At least once every 12 months after that.
- Upon automatic reenrollment of a member who is disenrolled only because he or she loses Medicaid eligibility for a period of two months or less, if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.
- When the state gives the intermediate sanction specified in Section 438.702(a)(4) which is

suspension of all new enrollment including default enrollment of a plan after a violation of any requirement of the act.
- Within the first ninety (90) days of Enrollment and after that during open enrollment periods: voluntary disenrollment does not stop members from filing a grievance with Molina Healthcare for incidents during the time they were covered by Molina.

Disenrollment with cause

You can ask to disenroll from the plan if:
- You move out of the MCO service area.
- The MCO does not, because of moral or religious objections, cover the service you seek.
- You need related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network, and your primary care provider or another provider determines that receiving the services separately would subject you to unnecessary risk.
- Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with your care needs.

To request to disenroll, you (or your representative) must submit an oral or written request to DHCFP or the MCO. If Molina receives a disenrollment request from a member, Molina will submit the request to DHCFP using the Disenrollment Form in Contract Attachment L—Disenrollment Form.

Involuntary disenrollment

You must be disenrolled from Molina Healthcare if you:
- No longer reside in the state of Nevada or Clark or Washoe counties.
- Are deceased.
- No longer qualify for medical assistance under one of the Medicaid eligibility categories in the eligible population.
- Become a nursing home resident for more than 180 days. For the purposes of determining eligibility for Nevada Medicaid, psychiatric residential treatment facilities (PRTF) and intermediate care facility for individuals with disabilities (ICFs/IID) shall not be considered a long term care facility.
- Become enrolled in a waiver program.
- Become eligible for Medicare coverage.

If you have a major life change, please call Nevada Division of Supportive Services at: (800) 992-0900 or go to their website **AccessNevada.DWSS.NV.gov**.

Molina may request disenrollment of a member in the following circumstances:
- If the continued enrollment of a member seriously impairs the MCO's ability to furnish services to either the particular member or other members;

- The member relocated his or her residence outside the MCO's service area;

The MCO must confirm that the member has been referred to the MCO's Member Services Department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the problem.

Molina may not request disenrollment in the following situations:

- An adverse change in the member's health status
- A pre-existing medical condition;
- The member's utilization of medical services;
- Diminished mental capacity;
- Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular member or other members);
- A member's attempt to exercise his/her grievance or appeals rights; or
- Based on member's national origin, creed, color, sex, religion, and age.

Transition of Care

Molina is committed to the best health outcomes for our members and will provide transition of care services. If you are new to Molina Healthcare, you may be able to keep your doctors and services for a period of time from your enrollment date.

- You may keep receiving care from your out-of-network provider for 90 days.
- If you are pregnant, you can receive care from your out-of-network provider until your baby is born and you have completed your first postpartum visit.

Molina Healthcare will help you choose new doctors and help you get services in our network. Your doctor may call Provider Services if they want to be in our network.

If you are transferring from Molina to another MCO or state FFS, Molina will share information with your new plan to provide continuity of care. Please contact us at (833) 685-2102 to request transition of care services or if you have questions about your care.

Renewal of benefits

You are required to renew your benefits every year. If you do not, you may lose your benefits. If you have moved since you originally signed up for Medicaid, you must call your local regional Medicaid office and tell them your new address or you will not receive a letter telling you when it is time to renew your benefits. For more information, visit **MolinaHealthcare.com/NV/RenewMyMedicaid**.

Reinstatement (Renewal of Molina Membership)
If you lose your Medicaid eligibility but regain it within (60) days, Molina will stay as your health plan. Molina will pick your previous PCP as long as your previous PCP is still in the Molina network. If you want a new PCP, call the Member Services Department at (833) 685-2102 (TTY/TDD: 711).

If you want to change your health plan, you must contact the Medicaid district office in Southern Nevada at (702) 668-4200, in Northern Nevada at (775) 687-1900, toll free at (800) 992-0900, or call Member Services at (833) 685-2102. You can call them at (800) 992-0900 (TTY: 711). We want you to be happy with your health plan. Please tell us why you are not happy with us. This will help us improve. Call Member Services at (833) 685-2102 (TTY/TDD: 711) and let them know the reason.

If you need to see a doctor that is not part of Molina or continue seeing a doctor after enrollment with Molina

Molina Healthcare protects your right to continuity of care (COC) and access to care for all its members. Molina Healthcare ensures many current treating providers and services as well as access to care for members will be maintained with existing providers, for members receiving current treatments, and approved prior authorized services at the time of enrollment that fall within continuity of care guidelines. It is your responsibility to report any on-going care corresponding to your plan of care at the time of enrollment. You have the right to continue treatment during a transition.

Molina also provides coverage for out-of-network providers when necessary services are not available within the network. If a Molina Healthcare Provider is unable to provide you with necessary and covered services, Molina Healthcare must cover the needed services through an out-of-network provider. There is no cost to the member.

Other insurance

Call Member Services to tell us you have:

- Medical insurance through your workplace.
- Been hurt at work.
- A worker's injury claim.
- A car accident.
- Filed a medical malpractice lawsuit.
- A personal injury claim.
- Other coverage or insurance.

It's important that we have this information. It will help us manage your services right.

Non-discrimination

Molina Healthcare may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's

status, ancestry, health status, or need for health services in the receipt of health services. If you think you have not been treated fairly, please call Member Services.

Grievance and appeals

Filing a grievance or appeal

If you are unhappy with anything about Molina Healthcare or its providers, you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know this. Molina Healthcare can help you with this process by calling Member Services. These services are free of charge. You can call us at (833) 685-2102 (TTY/TDD: 711) Monday through Friday from 8 a.m. to 6 p.m. A translator is available if you need to speak in your own language and can help you file your complaint, grievance, or appeal request. This service is free to all of our members. We can accept your complaint, grievance, or appeal from someone else with your permission.
For example:

- A friend.
- A family member.
- A provider who is a part of Molina.
- A provider that is not a part of Molina.
- A lawyer.

In order to be fair, cases will not be reviewed by the same person that made the first decision. all cases regarding medical services are reviewed by our medical staff. We keep files of all your cases and copies are available free of charge. Your file may include:

- All of your medical records.
- Documents related to your case.
- The info. from before and during the appeals process.
- Benefits, rules and criteria used to make the decision.

We will not take any bad action if your provider files a grievance or appeal for you.
To contact us you can:

- Call the Member Services Department.
- Visit **MolinaHealthcare.com/NV**.
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your Molina Healthcare member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.
  Mail your letter to:
  Molina Healthcare of Nevada, Inc.
  Attention: Grievance & Appeals Department
  PO Box 401820
  Las Vegas, Nevada 89140
  Fax numbers:

For instructions on how to file a grievance see page 61.

Member Grievances: (833) 412-3137
Member Appeals: (833) 412-3145

Email:
Member Grievances: **NV_Member_Grievance@MolinaHealthcare.com**
Member Appeals: **NV_Member_Appeals@MolinaHealthCare.com**

If you need a copy of Molina's Grievance/Appeal Form you may call Member Services or visit our website at **MolinaHealthcare.com/NV** under Member Materials and Forms.

If you send us your grievance/appeal request in writing, please include the following information:

- Your first and last name.
- Your signature.
- Date.
- Your Member ID number which can be found on the front of your Molina member ID card.
- Your address and telephone number.
- Your PCP's name and telephone number.
- A description of the issue.
- Any records related to your request.

Filing a grievance, or appeal will not affect the way Molina Healthcare of Nevada or its providers treat you.

Grievances
You or a provider acting on your behalf, or an authorized representative may file a grievance over the phone or in writing at any time. A grievance is an expression of dissatisfaction, regardless of whether you call it a "Grievance" received by Molina verbally or in writing about any matter or aspect of Molina or its operation, other than a Molina Adverse Benefit Determination.

Examples of complaints and grievances are, but are not limited to:

- You have a problem with the quality of your care.
- Wait times are too long.
- Your PCP or the PCP's staff is rude.
- You can't reach someone by phone.
- You are not able to get information.
- A PCP's office is not clean.
- Your enrollment with Molina ends and you did not ask for this.
- You cannot find a provider in your area.
- You are having trouble getting your prescription.
- Molina extended the timeframe for resolving a grievance or appeal.

We will send you a letter letting you know that we got your grievance within five (5) calendar days of getting your grievance. We may call your provider or get help from other Molina departments to investigate your grievance. You will get a letter with the outcome of your grievance as quickly as your health condition requires, but no later than ninety (90) calendar days from when we got your grievance.

For instructions on how to file an appeal see page 62.

You can ask for up to fourteen (14) extra calendar days to resolve your grievance. Also, Molina can take up to fourteen (14) extra calendar days if we need more information for your grievance. We will call you and send you a letter within two (2) calendar days of extending the timeframe. The letter will include the reason why we need more time and how the delay is in your best interest. At any time you may request a copy of your file, medical records or any material free of charge. You have the right to file a grievance if you disagree with the decision to extend the time frame.

Appeals

If you or a provider acting on your behalf, or an authorized representative got a Notice of Adverse Benefit Determination (denial letter) and you are unhappy with Molina's decision, you can ask for an appeal. In the event a provider files an appeal on your behalf, the provider must first obtain your written permission. An appeal is a request to look at an adverse benefit determination made by Molina. An adverse benefit determination (a decision not made in your favor) can be:

- For a resident of rural area with only one vendor, the denial of a member's request to exercise their right to obtain services outside the network (the geographic service area for this program does not include rural areas).
- Limiting or denying services.
- Reducing services.
- Suspending services.
- Terminating services.
- Denying payment for services.
- Failing to provide services in a timely manner.
- Failing to resolve appeals and grievances within timeliness guidelines.
- The denial of a request to dispute a financial responsibility, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial responsibilities.
- If applicable, decisions by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by the state with regard to the preadmission screening and annual resident review requirements.

All appeals must be filed within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (denial letter). You can file an appeal over the phone or in writing.
We will send you a letter letting you know that we got your appeal within five (5) calendar days of getting the appeal. We may call your provider or get help from other Molina departments to investigate your appeal. You will get a letter with the outcome

of your appeal as quickly as your health condition requires, but no later than thirty (30) calendar days from when we got the appeal request.

You can ask for up to fourteen (14) extra calendar days to resolve your appeal. Also, Molina can take up to fourteen (14) extra calendar days if we need more information for your appeal. We will call you and send you a letter within two (2) calendar days of extending the timeframe. The letter will include the reason why we need more time and how the delay is in your best interest. You have the right to file a grievance if you disagree with the decision to extend the time frame.

You have the opportunity to present Molina with evidence of the facts or law about your case, in person or in writing.

Non-emergency transportation is available if you need to bring your documents in person through the state's transportation vendor, MTM. You can call MTM at (844) 879-7341, Monday-Friday, 8 a.m. - 6 p.m.

Your appeal will be looked at by an individual with the appropriate clinical knowledge for your condition. In order to be fair, your appeal will be looked at by someone who was not involved in any previous level of review and is not an employee of the individual who made the first decision.

You, or someone legally authorized to do so, can ask us for a complete copy of your case file at any time, including medical records (subject to Health Insurance Portability and Accountability Act (HIPAA) requirements), a copy of the guidelines (criteria), benefits, other documents and records, and any other information related to your appeal. These can be provided free of charge.

Expedited appeals

You, your provider, or your authorized representative (you are required to designate in writing, the person or organization who you want to be your authorized representative) can ask for an expedited (fast) appeal if you think that waiting thirty (30) calendar days for an appeal decision could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. Molina can also expedite (rush) your appeal request based on the information we get.

Molina will decide if your request meets the guidelines for an expedited appeal resolution within twenty-four (24) hours of getting your expedited appeal request. If your appeal request does not meet the guidelines for an expedited (fast) appeal, we will still process your plan appeal within the regular thirty (30) calendar day timeframe. We will call you and send you a letter with this information within two (2) calendar days of getting your expedited appeal request.

If we do expedite (rush) your plan appeal, we will call you and send you a letter with the appeal resolution within seventy-two (72) hours of getting your expedited appeal request. Expedited (fast) appeals will be resolved as quickly as your health condition requires, but no more than seventy-two (72) hours from when we get the expedited appeal request. Please note the limited time available to present evidence if we expedite your appeal.

You can ask for up to fourteen (14) extra calendar days to resolve your expedited appeal. Also, Molina can take up to fourteen (14) extra calendar days if we need more information for your expedited appeal. We will call you and send you a letter within two (2) calendar days of extending the timeframe. The letter will include the reason why we need more time and how the delay is in your best interest.

At any time you may request a copy of your file, medical records or any material free of charge.

Continuing your benefits during the appeal process
Molina will continue your benefits while the health plan's internal appeal process is pending and while the State Fair Hearing is pending if all of the following conditions exist:

- Your request for continuation of benefits is submitted to the health plan on or before whichever is later:
  - within ten (10) calendar days of the health plan mailing the Notice of Adverse Benefit Determination.
  - or, the intended effective date of the health plan's proposed Adverse Benefit Determination.
- You file the request for an appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination notice.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original periods covered by the original authorization have not expired.
- You request an extension of benefits. You may have to pay for those services if the denial is upheld.

If you would like to continue with your benefits while you are appealing, you must file an appeal and meet all of the following guidelines:

- You asked for your benefits to continue within ten (10) calendar days from the date on the denial letter, or Notice of Adverse Benefit Determination letter, or on or before the date when changes to your benefit start, which date is later.
- The appeal involves services that Molina had already authorized.

- The service must have been asked for by an approved provider.
- The approved authorization has not expired.
- You asked for an extension of benefits.

Molina will provide benefits until one (1) of the following occurs:

- You withdraw the appeal.
- Ten (10) calendar days have passed from the date of the notice of appeal resolution and you have not asked for a Medicaid State Fair Hearing.
- The Division of Medicaid makes a State Fair Hearing decision that is not in your favor.
- The time period or service limits of a previously authorized service has expired.

To ask for your benefits to continue while your appeal is being looked at, you may call us or send your request in writing to:

NV Member Appeals & Grievances
Molina Healthcare Inc.
PO Box 182273
Chattanooga, TN 37422
Fax numbers:
Member grievances: (833) 412-3137
Member appeals: (833) 412-3145

Email:
Member grievances:
NV_Member_Grievance@MolinaHealthcare.com
Member appeals:
NV_Member_Appeals@MolinaHealthCare.com
If the final appeal decision is not in your favor, you may have to pay for the services you were getting while the appeal was being reviewed.

If the final appeal decision is in your favor and the services were not given to you while the appeal was being looked at, Molina will authorize the services for you as quickly as your health requires, but no later than seventy-two (72) hours from the date of the approval.

State Fair Hearing

If you are unhappy with an appeal decision that was made not in your favor, you or an authorized representative can ask for a State Fair Hearing. You can ask for a State Fair Hearing within ninety (90) calendar days of Molina's notice of appeal resolution.

You must first complete your plan-level appeal before asking for a State Fair Hearing with the Nevada Medicaid Hearings Unit. You can ask for a State Fair Hearing by sending your request in writing to:

Nevada Medicaid Central Office
State policy inquiries and Fair Hearing requests
Mailing Address:
4070 Silver Sage Dr.
Carson City, NV 89701
Phone: (877) 638-3472 and (775) 684-3600

Fax: (775) 684-3610
Email: **dhcfphearings@dhcfp.nv.gov**

You can also call Molina's Member Services Department and ask for help with a State Fair Hearing request. The Nevada Medicaid Hearings Unit will let you know in writing when they have received your State Fair Hearing request. They will let you know of their State Fair Hearing decision in writing as well.

When your appeal is about services you were getting, but they ended or were decreased, you can continue getting services during the State Fair Hearing. If you continue getting services, there will be no change in your services until a final State Fair Hearing decision is made. Please be sure to tell us if you want your services to continue.

If you continue getting services and the services are still denied after a State Fair Hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

Molina will meet the terms of the State Fair Hearing decision made by the Nevada Medicaid Hearings Unit. The Nevada Medicaid Hearings Unit's decision in these matters will be final. If the State Fair Hearing decision is to reverse an Adverse Benefit Determination made by Molina, Molina will pay for all costs associated with the hearing.

Member rights and responsibilities

Did you know that as a member of Molina Healthcare, you have certain rights and responsibilities? Knowing your rights and responsibilities will help you, your family, your provider and Molina Healthcare ensure that you get the covered services and care that you need. These rights and responsibilities are posted in providers' offices. They are also posted at **MolinaHealthcare.com**. You have the right to:

- To be treated with respect and recognition of their dignity and need for privacy;
- To be provided with information about the Contractor, its services, the practitioners providing care, and Members' rights and responsibilities in accordance with 42 CFR 438.10;
- To be able to choose primary care practitioners, including specialists as their PCP if the Member has a chronic condition, within the limits of the Network, including the right to refuse care from specific practitioners;
- To participate in decision-making regarding their health care, including the right to refuse treatment;
- To pursue resolution of Grievances and Appeals

about the Contractor or care provided;
- To formulate Advance Directives;
- To have access to his/her medical records in accordance with applicable federal and state laws and to request that they be amended or corrected as specified in 45 CFR Part 164;
- To guarantee the Member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; and
- To ensure the Member is free to exercise his or her rights without the Contractor or Network Provider treating the Member adversely.

To get a free copy of the handbook in the mail, call Member Services at (833) 685-2102 (TTY: 711) Monday to Friday, from 8 a.m. to 6 p.m. You can also request a copy in other formats and languages.

It will be mailed within 5 business days.

Your responsibilities

- Providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- Paying for the cost of unauthorized services obtained from non-participating providers.
- Reporting unexpected changes in your condition to the health care provider.
- Reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
- Following the care plan that you have agreed on with your provider.
- Being on time to appointments.
- Keeping appointments and, when you are unable to do so for any reason, to notify the health care provider or healthcare facility.
- Assuring that the financial obligations of your health care, if any, are fulfilled as promptly as possible.
- Following health care facility rules and regulations affecting patient care and conduct.
- Understanding your health problems and participating in developing mutually agreed-upon treatment goals to the degree possible.
- Reporting truthful and accurate information when applying for Medicaid (you will be responsible to repay capitation premium payments if your enrollment is stopped due to failure to report truthful or accurate information).

- Formulating advance directives and to expect that those directives will be carried out.
- Reporting fraud and abuse when you are aware.

Advance directives or living will

Emancipated minors and members over 18 years of age have the right to make choices about their health. You have the right to have or not have medical care. You can make this happen at any time. This form is called an advance directive or living will. This form allows your family and provider know what care you want or don't want. It also says when to stop care that will continue your life in case of a serious illness.

An advance directive is a written statement by you, telling how you want medical decisions made if you become unable to decide for yourself. There are a few types of advance directives:

Living will or declaration — a living will tells your health care providers and family about the type of life-sustaining actions you want, and do not want, if you suffer from a terminal illness or an irreversible condition. A living will does not apply unless you cannot make decisions for yourself; until then, you'll be able to say what treatments you want or don't want.

Durable power of attorney for health care — a durable power of attorney for health care will let you pick a person to make decisions for you when you can't make them yourself. You can also include information about any treatment you want or do not want. Ask your PCP or specialist about these forms. You can have either a living will or a durable power of attorney for health, or you can have both documents. A living will is your personal statement regarding the types of life-sustaining treatment you want if you are not able to share your desires. A durable power of attorney for health care covers more than the living will. It covers any medical decisions, not just decisions concerning life-sustaining treatment.

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

- Ask your PCP for a living will form, or call Member Services to receive one.
- Fill out the form.
- Take or mail the completed form to your PCP or specialist; your PCP or specialist will then know what kind of care you want to receive.

You can change your mind any time after you have signed a living will:

- Call your PCP or specialist to remove the living will from your medical record.
- Fill out and sign a new form if you wish to make changes in your living will.

Your PCP will require you to sign the Acknowledgement of Patient Information on Advance Directives form. Your signed form, along with your advance directive, will be kept on file with your medical record.

Member rights with an advance directive

You have:

- The right to accept or refuse medical treatment and to formulate Advance Directives; and
- The right to execute an Advance Directive, including a requirement that the network provider present a statement of any limitation in the event the Network Provider cannot implement an advance directive on the basis of conscience. (At a minimum, the network provider's statement of limitation, if any, must clarify any difference between institution-wide objections and those that may be raised by the individual's Network Providers; identify the State legal authority pursuant to NRS 449.628 permitting each objective; and describe the range of medical conditions or procedures affected by the conscience objection.)

You should tell your Network Provider to document in your medical record whether you have executed an Advance Directive. The provider should not base your care or otherwise discriminate against you based on whether or not you executed an Advance Directive.

If you have a complaint concerning the advance directives requirements you may file with the appropriate State agency, which regulates Molina. Molina Healthcare will show change in state law in this information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. Sample advance directives policies, procedures and forms, as well as patient information concerning Nevada law, are available on the State's website: **dhcfp.nv.gov/Resources/PI/AdvanceDirectives/**. Molina Healthcare will notify you once a year that this information is available in the member handbook.

Right to object

Nevada law says your PCP and other providers, individually and/or institutionally, have the right to object to the request you make in your advance directive. You can find the law in the Nevada Revised Statutes Annotated Section 449.628.

Individual and institutional objection

An individual objection is when your individual PCP or other providers treating you will not honor your advance directive on the basis of their conscience (beliefs).

An institutional objection is when an entire institution, like a hospital or health system, will not honor your advance directive for reasons of conscience (beliefs). The range of medical conditions that may be objected to by individual and institutional providers could be different from provider to provider. Be sure to ask your

PCP and other providers if they have objections to the requests you have included in your advance directive. If your PCP or other provider objects to the request for care you make in your advance directive, you have the right to select another PCP or provider who will honor your request. Please call Member Services at (833) 685-2102 (TTY 711), Monday through Friday from 8 a.m. to 6 p.m. for help.

Fraud and Abuse

Molina Healthcare's Fraud and Abuse Plan benefits Molina, its employees, members, providers, payers and regulators by increasing efficiency, reducing waste, and improving the quality of services. Molina Healthcare takes the prevention, detection, and investigation of fraud and abuse seriously, and complies with state and federal laws. Molina Healthcare investigates all suspected cases of fraud and abuse and promptly reports to government agencies when appropriate. Molina Healthcare takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or termination of membership. You can report potential fraud, waste and abuse without giving us your name.

To report suspected Medicaid fraud, contact Molina Healthcare AlertLine at:

Toll free, (866) 606-3889
Or
Complete a report form online at:
MolinaHealthcare.alertline.com

Email: **ir_siuteam@MolinaHealthcare.com**
Call: (866) 606-3889
Mail to:
Molina Healthcare. Inc.
Attention: Special Investigations Unit
P.O. Box 22625, Beach, CA 90802

Definitions:

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

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for them or some other person. It includes any act that constitutes fraud under

applicable Federal or State law. (42 CFR § 455.2) Here are some ways you can help stop fraud:

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

Member privacy

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

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

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

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

Standard member material terminology and definitions

Appeal A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Co-payment A payment paid by you in order to receive medical care.

Durable medical equipment Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency medical condition A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency medical transportation Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

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

Emergency services Covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under Title 42.
- Needed to evaluate or stabilize an emergency medical condition.

Excluded services Services that are not covered under the Medicaid benefit.

Grievance A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

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

Health insurance Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Home health care Health care services a person receives in the home including nursing care, home health aide services and other services.

Hospice services A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization The act of placing a person in a hospital as a patient.

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

Medically necessary This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Nevada Medicaid coverage rules.

Network A network is a directory of doctors, health care professionals, hospitals, and health care facilities that a plan has contracted with to provide medical care to its members.

Non-participating provider A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan.

Physician services Care provided to you by an individual licensed under state law to practice medicine, surgery, behavioral health.

Plan Plan refers to a managed care organization offering medical services to its members.

Preauthorization A decision by your plan or the DHCFP that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.

Participating provider Providers, hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports that are contracted with your health plan. Participating providers are also "in-network providers" or "plan providers."

Post-stabilization Covered Services Covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition.

Premium A monthly payment a health plan receives to provide you with health care coverage.

Prescription drug coverage Prescription drugs or medications covered (paid) by your health plan. Some over-the-counter medications are covered.

Prescription drugs A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary care physician Your primary care physician is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Primary Care Provider (PCP)

Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often, they are the first person you should contact if you need health care. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the health plan member's pregnancy.

Provider A person who is authorized to give health care or services. Examples of providers include doctors, nurses, behavioral health providers, nursing homes and specialists.

Rehabilitation services and devices Treatment you get to help you recover from an illness, accident, or major operation to restore you to the best possible functional level.

Skilled nursing care Skilled nursing care means assessments, judgments, interventions and evaluations of intervention, which require the training and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:

- Performing assessments to determine the basis for action or the need for action.
- Monitoring fluid and electrolyte balance.
- Suctioning of the airway.
- Central venous catheter care.
- Mechanical ventilation.
- Tracheotomy care.

Specialist A doctor who provides health care for a specific disease or part of the body.

Urgent care Care when you need to see a doctor and your doctor is not able to see you or the office is closed. Care is needed for a sudden illness, injury, or condition that is not an emergency but needs to be treated right away.

Molina Healthcare of Nevada
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