MolinaHealthcare.com

Welcome to Molina Healthcare.

Nevada (Medicaid and Nevada Check Up program)

MOLINA® HEALTHCARE

Non-Discrimination Notification
Molina Healthcare of Nevada
Medicaid

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

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

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

If you need these services, contact Molina Member Services at (833) 685-2102, TTY: 711, Monday - Friday, 8 a.m. to 6 p.m. PST.

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

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can fax your complaint to (505) 342-0595, or e-mail your complaint to civil.rights@molinahealthcare.com.

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

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

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

If you need help, call (800) 368-1019, TTY (800) 537-7697.

Language Assistance Services
Molina Healthcare of Nevada
Medicaid

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-(833) 685-2102 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(833) 685-2102 (TTY: 711).

French Creole (Haitian Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-(833) 685-2102 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(833) 685-2102 (TTY: 711).

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-(833) 685-2102 (TTY: 711).

Chinese
注意 : 如果您使用繁體中文 , 您可以免費獲得語言援助服務。請致電 **1-(833) 685-2102** (**TTY**:**711**) 。

French
ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-(833) 685-2102 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(833) 685-2102 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(833) 685-2102 (телетайп: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-(833) 685 2102 (رقم هاتف الصم والبكم: 711).

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-(833) 685-2102 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-(833) 685-2102 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-(833) 685-2102 (TTY: 711) 번으로 전화해 주십시오.

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-(833) 685-2102 (TTY: 711).

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-(833) 685-2102 (TTY: 711).

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-(833) 685-2102 (TTY: 711).

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 Department of Health and Human Services (DHHS), 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 AS EVIDENCE OF INSURANCE COVERAGE BETWEEN CONTRACTOR AND THE MEMBER

The most current version of the handbook is available at **MolinaHealthcare.com.**

In this handbook you will find helpful information about:

Your Membership (pg 7)

- Member ID Card
- Quick Reference
- Phone Numbers

Your Provider (pg 13)

- Find your Provider
- Schedule your First Visit
- Interpreter Services

Your Benefits (pg 19)

- Molina Network
- Vision and Dental
- Value Added Benefits
- Covered Medications

Your Extras (pg 25)

- Health Education
- Health Programs
- Molina Mobile App
- Community Resources

Your Policy (pg 41)

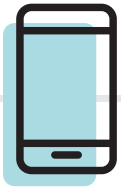
- Coverage
- Billing
- Rights and Responsibilities

NOTE: If you have any problem reading or understanding this or any Molina Healthcare information, call Member Services at 1- (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
You should have received your Molina Healthcare ID card. 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.

2. 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 and more. Connect from any device, anytime!



3. 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.

4. 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.

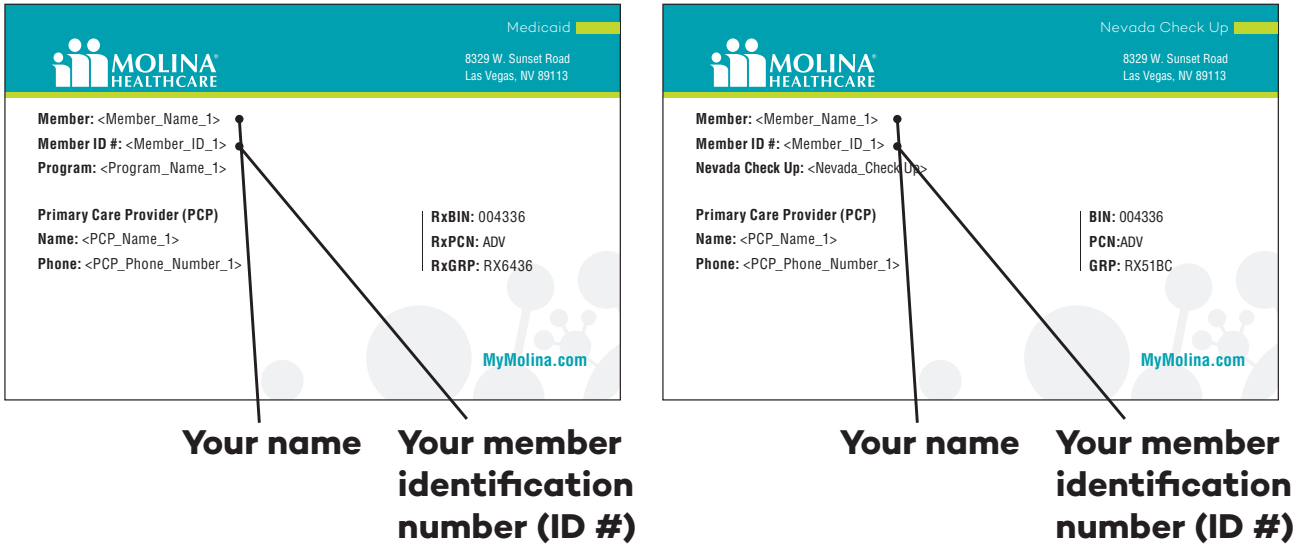
5. Get to know your benefits

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 for each Member.



You need your ID card to:

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

Quick Reference

Need	Emergency	Online Access	Getting Care

		- Find or change your provider
		- Update your contact information
		- Request an ID card
		- Get health care reminders
		- Track office visits
			- Urgent Care
			  - Minor illnesses
			  - Minor injuries
			- Physicals and checkups
			- Preventive care
			- Immunizations (shots)

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**	**Call Your Doctor:** Name and Phone **24-Hour Nurse Advice Line** 1- (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**

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 infant visits with PCP or OB/GYN

Member Services
1- (833) 685-2102, TTY/TDD 711
Monday to Friday
8:00 a.m. to 6:00 p.m. (PST)
Non-emergency Transportation Services Provided by MTM:

1- (844) 879-7341 or
1- (833) 685-2102, TTY/TDD 711

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

Changes/Life Events

- You Moved
- Change in Name/ Address
- Become Pregnant
- Marriage/Divorce
- You Have a Baby
- Change your Health Coverage

Member Services
1- (833) 685-2102, TTY/TDD 711
Nevada Division of Medicaid
1- (877) 638-3472
(Deaf and Hard of Hearing 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 to get to know your provider. Call your PCP right away if you need to cancel or reschedule your appointment. You can also call Molina Healthcare at 1- (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.

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

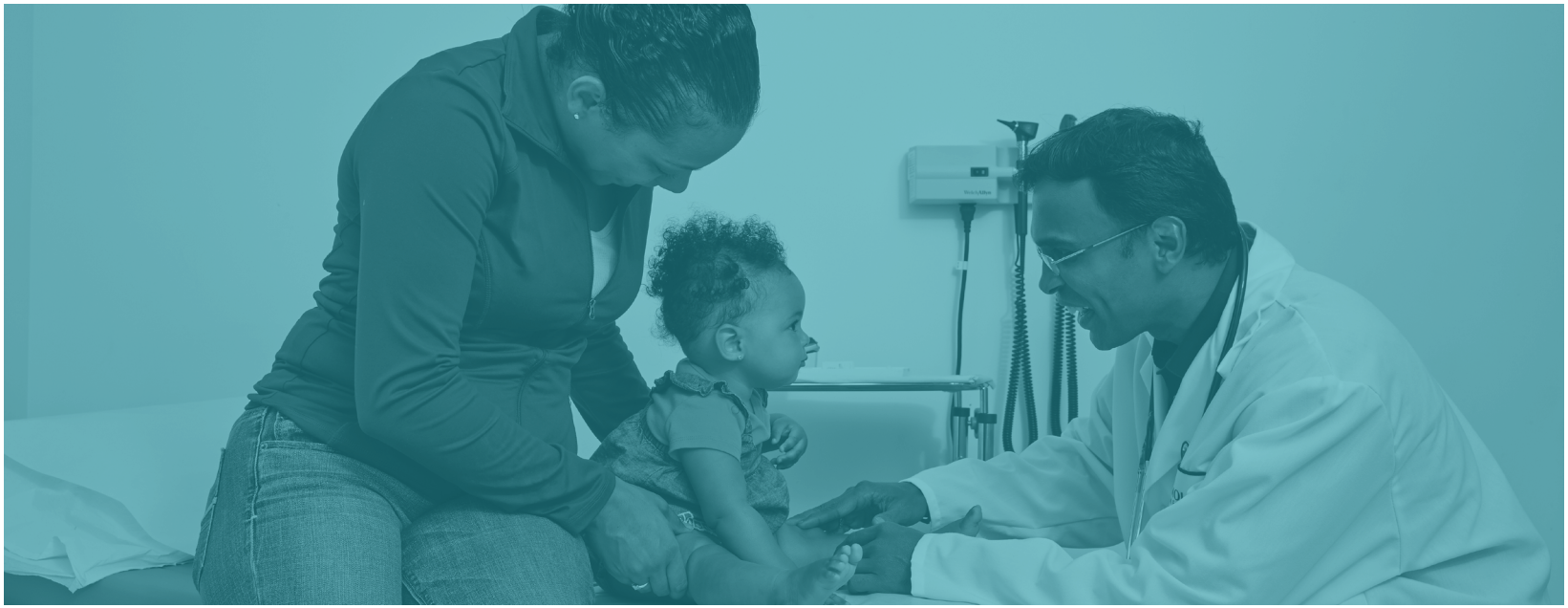
If you need to speak in your own language, we can assist you. Call Member Services and we can assist you in your preferred language through an interpreter. An interpreter can help you talk to your provider, or pharmacist, or other medical service providers. We offer this service at no cost to you. An 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. The number is on the back of your member ID card. 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.

If you change your PCP, Molina Healthcare will send you a new ID card.



Remember, you can call the Nurse Advice Line at any time. Our nurses can help if you need urgent care. Call 1- (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 **MolinaHealthcare.com/ProviderSearch.** 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. You may also go to your WIC center where a printed copy of the Molina Provider Directory will be available.

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:

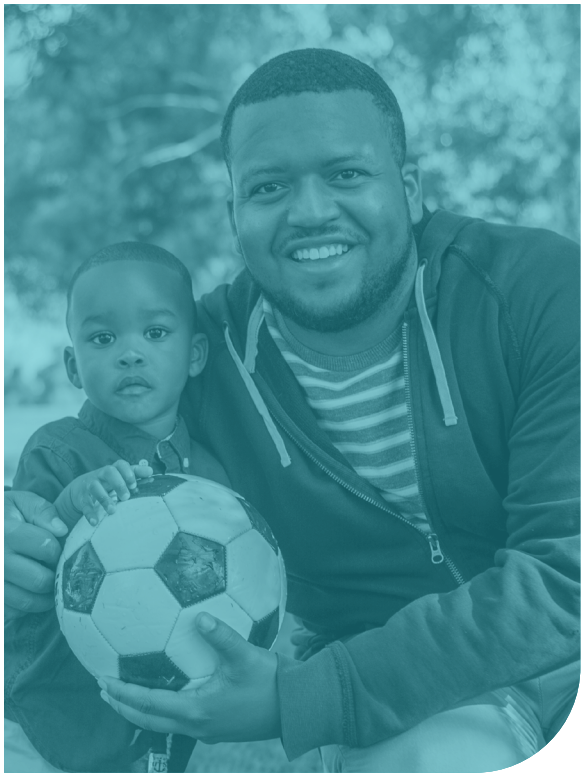
1. Provider's name as well as any group affiliation;
2. Street address(es);
3. Telephone number(s);
4. Web site URL, as appropriate;
5. Whether the provider will accept new enrollees;
6. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered 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 FQHCs and RHCs by area of the State;

9. Identification of any restrictions on the Member's freedom of choice among network providers;
10. Identification of Closed Panels (web-based version only); and
11. Identification of hours of operation including identification of Providers with non- traditional hours (before 8 a.m. or after 5 p.m. PST or 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
- Residency completion
- Board Certification status

For a full list of covered services, please refer to page 44. You may also request a copy of the Provider Directory.



Vision

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

- **Annual preventive eye exams**
- **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**
- **Services Manual: http://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 1- (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.**

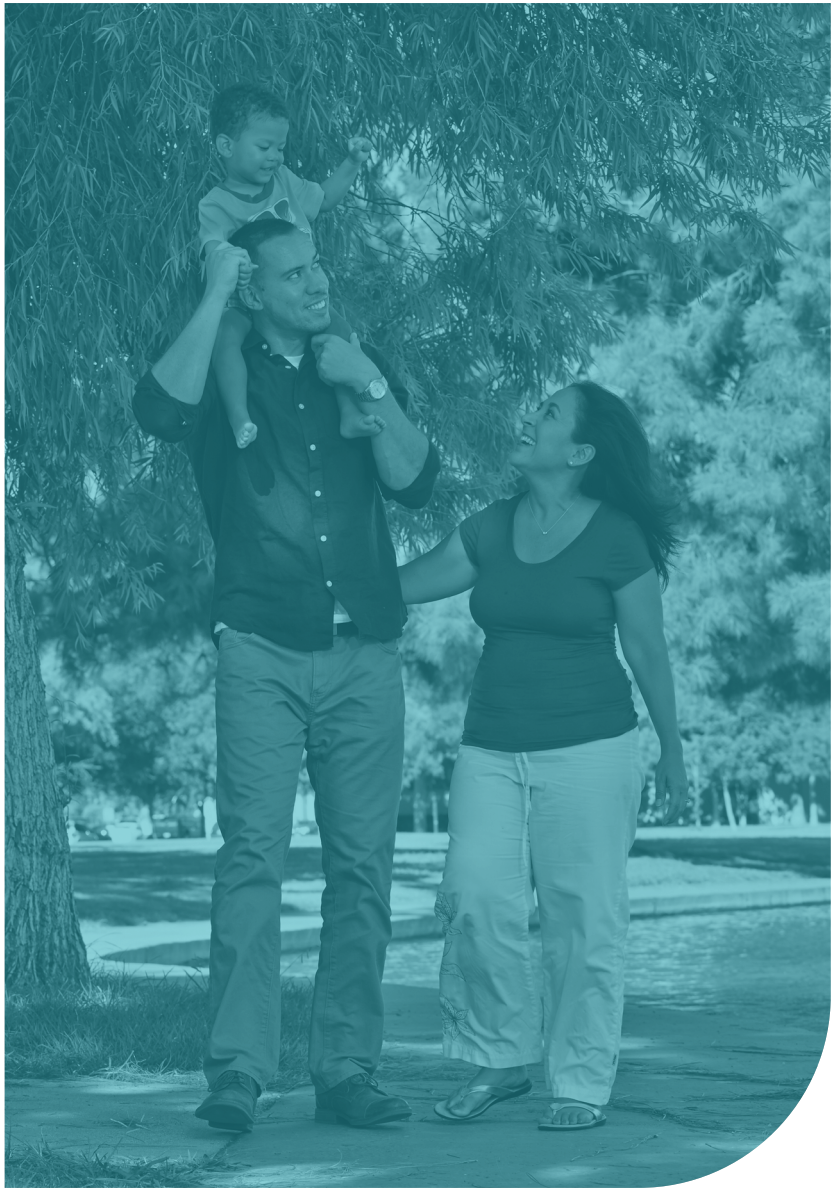
Covered Medications

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 to prescribe.

Most generic drugs are included in the list. You can find a list of the preferred drugs at **MyMolina.com.**

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 needs
- Access your medical records

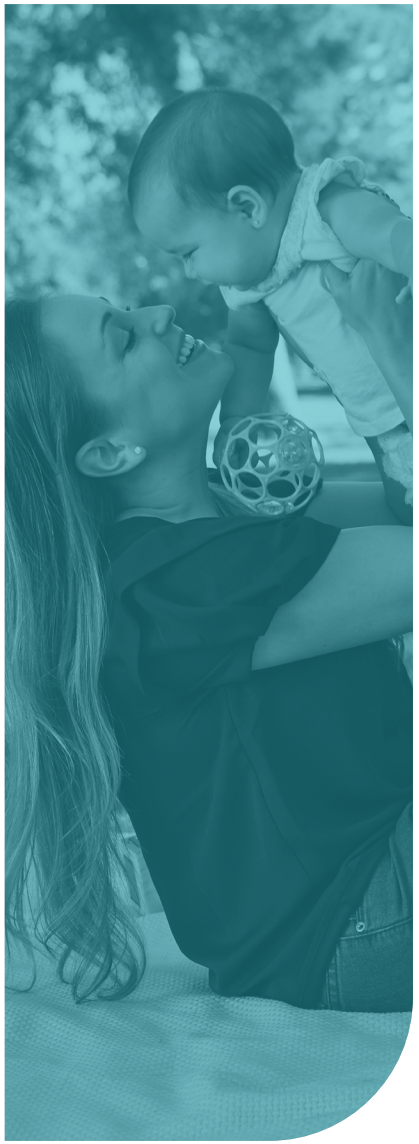
You can download the app for free on your smartphone using the App store for Apple and Google Play for Android.

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 diseases. 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 illness, 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: 1- (866) 472-9483 TTY/TDD 711.

Chronic Illness: 1- (866) 891-2320 TTY/TDD 711.



Pregnancy Rewards

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,

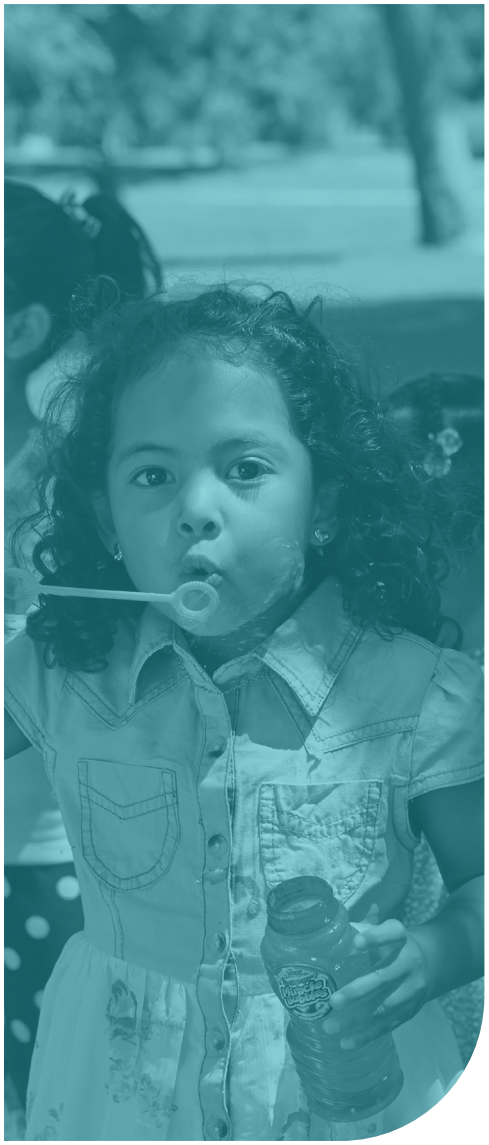
Transportation

Lean on Molina for enhanced transportation benefits, like rides to food banks, WIC appointments, job training or interviews 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 1- (844) 879-7341, TTY/TDD: 711 or call Member Services at 1- (833) 685-2102, TTY/TDD: 711.

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

Call to schedule your ride. You must give at least 5 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!

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.

- Community 4 Me 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) 1- (800) 863-8942
- Department of Health 1- (775) 623-6575
- Molina Care Management 1- (844) 809-8438, TTY/TDD 711

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Annual Baby Shower	Attend a Molina baby shower.	Members who are currently pregnant (moms-to-be) and their guests. Only [2] additional family members.	$100 gift card/ incentive (member only)	
Costco Gold Star Membership	Receive one free Costco membership per year	All Members	One free Costco Gold Star membership per family	
Insulin and Blood Glucose Program	**Glucometer and Test Strips** Molina provides each member with a glucometer at no cost to help them with the day-to-day management of their insulin levels, reduce episodes of severe hypoglycemia, and empower self-care.	Members with Type 2 diabetes	One glucometer per member.	
Electronic Breast Pump	For new mothers with an infant in the NICU, who wish to obtain electronic breast pumps.	12 years & older (New Moms)	One per member	
Healthy Rewards	Attend one postpartum visit 7-84 days after the birth of the baby	12 years & older (New Moms)	$25 Gift Card	
	Complete a prenatal visit during their first trimester or within 42 days of enrollment	12 years & older (Pregnant Women)	Car or Booster Seat	

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Healthy Rewards	Receive 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; limited to one per member per year	50-74 years old (female)	$25 Gift Card	
	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 or more well-child visits when the child is between 15-30 months old	15-30 months old	Max $25 Gift Card	
	Complete a well-child visit annually	3-20 years old	$25/visit (Max $25 Gift Card per year)	
	Complete an office visit for cervical cancer screening (pap test)	21-64 years old (female)	$25 Gift Card	
	Complete an annual chlamydia screening	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 VS Complete a follow-up PCMH or participating primary care physician visit within seven days of an inpatient hospitalization or behavioral health stay, unlimited - All members - $50 Gift Card	Complete annual adult preventive screening visit (limited to one per year)- 18 years and older - $25 Gift Card	Complete annual preventive dental visit (limited to one per year) - 6-18 years old - $25 Gift Card

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Healthy Foods Program	For members experiencing food insecurity and a high-risk condition such as diabetes or high-risk pregnancy.	For high-risk members with chronic conditions including high risk pregnant mothers.	The program provides a prescription food box. **Limit one per household**	
Transition meals for members who are pregnant or postpartum	Members may request home delivered meals that can support the nutritional needs during pregnancy and when breastfeeding	Members who are pregnant or through the first year postpartum	Mom's Meals is $7 per meal at 3x day for 1 week ($147)	Yes
Through Pacify – new moms receive a package of items to support postpartum	Members who sign-up for Pacify are eligible to receive a gift with package that includes a Pacify box, burp cloth, and guide card.	Medicaid Members	$25 value	
Text Program	**TEXT4BABY** helps prepare members for motherhood by sending appointment reminders, personalized information on prenatal care, baby's development, signs of labor, breastfeeding, and nutrition directly to members' phones at no cost.	Pregnant members and members with children under one year of age	None	

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Doula assistance services	Members may request doula assistance during labor and delivery to provide emotional and physical support to the laboring mother and her family	Pregnant Members	Two Prenatal visits, two Postpartum visits and one visit for delivery assistance	Yes
Syphilis screening	Complete an annual syphilis screening and treatment prior to giving birth	16-24 years old (female)	$25 Gift Card	
Genetic Testing Program	We cover genetic tests that are needed to determine the most effective course of care for oncology treatment	Members requiring oncology treatment	1 per member	
School/Sports Physical	Receive one free physical for school or sports per year	6-18 years old	Free annual physical	
Vision	Additional $100 above the standard benefit for medically necessary and appropriate services (such as corrective lenses or contacts) every 24 months	21 years and older	$100	
Obesity/ Weight Watchers	Members who receive prior authorization from the health plan can receive up to 13 weeks of Weight Watchers services; can be referred by providers, internal departments (care managers, etc.), or by self-referral	All members	$45 value ($3.30 week digital)	Yes

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Health In Touch Mobile App	Members actively enrolled and participating in Molina programs that have communication access barriers may be eligible to receive prepaid wireless service and goods when they are actively engaged with their Molina program representative. Molina will have the option to purchase from Truconnect prepaid wireless devices and services for our members. The free service plan supported by Truconnect includes unlimited talk/ text and free international calling to Mexico, Canada, China, Vietnam and Korea. Free calling to Truconnect and Molina for support.	Members actively enrolled and participating in Molina programs that have communication access barriers	One per household	

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Health in Touch	Members who qualify for the federal Lifeline program will receive a free or discounted wireless devices and service plans. The free service plan supported by Truconnect includes unlimited talk/text and free international calling to Mexico, Canada, China, Vietnam and Korea. Free calling to Truconnect and Molina for support. Molina will have the ability to preload Molina selected apps for select devices.	Members who qualify for the federal Lifeline program	Free – no cost for member	
Replace Lost ID Card or Birth Certificate	ID cards and Birth Certificates	Parents of Medicaid Members	Varies based on household	
CVS discount card	Members receive 20% discount on thousands of regularly priced CVS brand health-related items	All members	Varies by usage	

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Asthma	Members who sign up and complete the three-month Asthma Disease Management Breathe with Ease® Program 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.	Mattress/Pillow: All members in the Asthma Disease Management program 2nd Inhaler: 6-18 years old	Mattress Cover: $60 Second Inhaler: No cost for member Pillow Covers: $20	
Over the counter medication – including pregnancy tests	Medicaid members	All members	$30 per member household, per quarter for commonly-used OTC items not covered through Nevada Medicaid our affiliate pharmacy benefit manager and its mail order program.	

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Additional transportation benefit to SDOH resources and added family members	Lean on Molina for enhanced transportation benefits, like rides to food banks, WIC appointments, job training or interviews and more. Members need to request and receive approval for these requests through their care manager.	All members	Provides transportation to food banks, WIC, domestic violence agencies, housing authority and job interview or training. Only [2] additional family members.	Yes
School Nutrition Program Molina to collaborate with local schools on initiatives and programs to educate students and their families on the importance of healthy living.	Children who participate in the program will receive Health and Education Books focuses on obesity prevention, healthy eating, asthma, diabetes, and the ills of smoking.	Children up to age 18	$25 value	

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Boys and Girls Club	To assist our young members in developing social and leadership skills, we will sponsor the membership fee to local Boys and Girls Clubs. This benefit will be available to members ages 6-18 years old.	We will provide youth-organization membership dues to the Boys & Girls Club program, for qualified members under the age of 19.	$10-$15 per child (depends on the individual club)	
GED	Vouchers to take GED test for free at authorized testing centers Gift card for passing exam	18 years and older 18 years and older	$134 value $50	
Alternatives to Opioids	Molina will offer coverage for acupuncture and massage therapy	Members ages 21+ with chronic pain	Adult members can receive up to $150 to use towards these services.	Yes

Program	Member Action	Eligible Populations	Amount/ Service Caps	PA Required
Community 4 Me 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 that state in the areas of health, financial support, education, emergency resources, legal support, housing, employment opportunities, transportation, and food security.	All members	Free – no cost for member	
Respite Unit	Molina provides respite care to allow self-care time to recharge and rejuvenate.	Member's caregiver	8 hours per year of respite care	Yes

Your Policy

Language Services

If you have any problem reading or understanding this information or any other Molina Healthcare information, please contact Member Services at 1- (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 1- (833) 685-2102, or TTY/TDD 711. If you are hearing or sight 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:

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 Seventy-two (72) hours
Behavioral health life threatening emergency	Immediately
Follow up routine care visit	14 days

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 Trimesters	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.

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. Your PCP should call you back within 30 minutes. Talk to your PCP and set up an appoinment.

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 1- (833) 685-2102, TTY/TDD 711; we can help you arrange for your prenatal care. Or, if you want to avoid pregnancy, ask about family planning options.

If you have a major life change, please call Nevada Check Up and Medicaid. The phone number for Nevada Check Up is 1-877-543-7669. The phone numbers for NV Medicaid are Las Vegas District Office: (702) 668-4200 and Reno District Office: (775) 687-1900. You can visit one of their local offices or go to their website.

The websites for Nevada Check Up are www.nevadahealthlink.com or https://dwss.nv.gov/Medical/NCUMAIN/. The website for Nevada Medicaid is accessnevada.dwss.nv.gov. Contact them as soon you have big a change in your life

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 call 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.

Covered Services	Limitation
Ambulatory Surgical Center Services	*Medically necessary surgeries All Medicaid policy restrictions apply*
Behavioral Health/ Substance Use 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 EPSDT Program and screened by their PCP.
Certified Community Behavioral Health Centers (CCBHC).	Referral and coordination of care. *All Medicaid Policy restrictions apply*
Dental Services –	For Children under 21 years of age provided by Nevada Medicaid through Liberty dental. For adults, 21 years of age and older, it only covers emergency dental examinations and extractions, and in some instances false teeth (full and partial dentures to replace missing teeth). Contact Liberty Dental
Diabetic lab work and retinal eye screening	Annually

Covered Services	Limitation and Description
Dialysis	Freestanding or hospital-based center services
Durable Medical Equipment	*All Medicaid policy restrictions apply*
Emergency Ambulance services	Medically necessary ground an emergency helicopter 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	Under age 21, one exam every 12 months. Age 21 and older, one exam every 24 months. All members, lenses and frames every 12 months

Covered Services	Limitation and Description
Family Planning Services	unlimited, no referral needed. Members can receive family planning services from plan or non-plan providers.
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
Home Health Services	Same day for Members with urgent needs Non-urgent care within fourteen (14) Calendar Days
Hospital Services	Inpatient and Outpatient
Hysterectomy	Excluded benefit
Laboratory Services	*All Medicaid policy restrictions apply.* *No PA are needed for emergencies.*

Covered Services	Limitation and Description
Mammogram/Pap Smears	No prior authorization required
Medical Supplies	*All Medicaid policy restrictions apply*
No co-pays	
OB/GYN and Nurse Midwife services	Including Prenatal and Postpartum visits
Physician office services, Physician Assistant services office visits and Nurse Practitioner office visits	No Limit
Podiatrist Services	Routine foot care is not covered. 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

Covered Services	Limitation and Description
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
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.
Vaccines	EPSDT immunizations, flu shots, and pneumonia vaccines

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 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 CHECK UP OR 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.*
- Nonemergency 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. Pacific time. 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 or Nevada Check Up.

**Nonemergency transportation is available for Medicaid recipients through the state's transportation vendor, MTM. As of August 24, 2011, nonemergency transportation service is no longer

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; or
- 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. If deemed medically necessary Please include a statement that EPSDT services are provided at no cost.

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 depressing 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, and
- Supplemental Nutrition Assistant 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, and then,
- once a year for ages 3-21 years old.

If you need help accessing EPSDT services for your child, please call Member Services 1- (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.

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.

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 1- (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.

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 a letter within three (3) days of the denial. 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. 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. You can get care (24) hours a day, (7) days a week. 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 1- (833) 685-2102, TTY/TDD 711. You may also visit our website at **MolinaHealthcare.com**.

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. You can also call Member Services for help.

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). Your provider will need to explain why you need a certain drug or a certain amount of a drug. We must approve the PA request before you can get the medication. Reasons why we may require PA of a drug include:

- There is a generic or
- 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 PA 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.

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 **MolinaDrugList.com/NV/Medicaid.** 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 1- (833) 685-2102, TTY/TTD 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. 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 mental health and/or substance abuse services, call Nurse Advice Line for information at 1- (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. 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 recover 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 **http://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 Medicaid about eligibility. They are open Monday through Friday from 8:00 a.m. to 5:00 p.m. Their number is 1- (877) 638-3472, 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".

Other Insurance:
You must let Molina and Medicaid know if you have other insurance coverage with another company. Molina can help coordinate your other benefits with your other insurance company.

Open Enrollment:
If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment".

You do not have to change health plans. If you choose to change health plans during open enrollment, you will begin in the new health plan at the end of your current enrollment year. Whether you pick a new health plan or stay in the same health plan, you will be locked into that health plan for the next 12 months. Every year, you may change health plans during your 60 day open enrollment period.

Disenrollment:
Members may change their plan selection within the first ninety (90) days of Enrollment and thereafter during open enrollment periods. Voluntary disenrollment does not stop Members from filing a grievance with Molina Healthcare for incidents occurring during the time they were covered by Molina.

You can ask to disenroll from the plan if the services you want are not covered because of moral or religious reasons.

Involuntary Disenrollment:
You must be disenrolled from Molina Healthcare if You:
1. No longer reside in the state of Nevada;
2. Are deceased;
3. No longer qualify for medical assistance under one of the Medicaid eligibility categories in the eligible population;
4. Become a nursing home resident. For the purposes of determining eligibility for Nevada Medicaid, PRTF's and ICF/IIDs shall not be considered a long term care facility;
5. Become enrolled in a waiver program;
6. Become eligible for Medicare coverage; or
7. Are diagnosed with hemophilia.

If you have a major life change, please call Nevada Check Up and Medicaid. The phone number for Nevada Check Up is 1-877-543-7669. The phone numbers for NV Medicaid are Las Vegas District Office: (702) 668-4200 and Reno District Office: (775) 687-1900. You can visit one of their local offices or go to their website.

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/NVRenew**.

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 1- (833) 685-2102, TTY/TDD 711.

If you want to change your health plan, you must contact the Division of Medicaid. You can call them at 1- (800) 777-1840, 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 1- (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. The cost to you should be no

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 1- (844) 685-2102, TTY/TDD 711 Monday to Friday from 8:00 a.m. to 6:00 p.m. (PST). 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 part of Molina
- A provider that is not 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, or
- Visit **MolinaHealthcare.com**, or
- 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

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

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 with the exception of an expedited appeal. 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:

- 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;
- For a resident of a rural area with only one (1) Managed Care Organization in the area, the denial of a request to exercise his or her right to get services outside the Molina network;
- The denial of a request to dispute a financial responsibility, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial responsibilities; or
- If applicable, decisions by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a 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. If you call to file your appeal, you must send Molina a signed, written appeal request after you first called us, unless you ask for an expedited (fast) plan appeal. 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.

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 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 for 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 Plan's internal Appeals 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 Plan on or before the later of the following: within ten (10) Calendar Days of the Plan mailing the Notice of Adverse Benefit Determination; or, the intended effective date of the 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; and

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; and
- 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 not in your favor; or
- The time period or service limits of a previously authorized services 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:

Molina Healthcare of Nevada
Attention: Grievance & Appeals Department

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 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 Division of Medicaid
Nevada Medicaid Hearings Unit
1100 East William Street-Suite 101
Carson City, NV 89701
Fax # (775) 684-3610
E-mail: **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 provider's offices. They are also posted at **MolinaHealthcare.com**. You have the right to:

- To be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy
- To request and obtain information on any limits of your freedom of choice among network providers
- *To be able to choose primary care practitioners, including specialists as your*

PCP if you have a chronic condition, within the limits of the plan network, including the right to refuse care from specific practitioners

- To a prompt and reasonable response to questions and requests
- To know who is providing medical services and who is responsible for your care
- To know what patient support services are available, including whether an interpreter is available if you do not speak English
- To know what rules and regulations apply to your conduct
- Receive information in a manner and format that may be easily understood
- To be given by health care provider information concerning diagnosis, planned course of treatment, treatment options, alternatives, risks, and prognosis in a manner appropriate to your condition and ability to understand
- To be able to take part in decisions about your health care
- To have an open discussion about your medically necessary treatment options for your conditions, regardless of cost or benefit
- To be free from any form of restraint or seclusion used as means of coercion discipline convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion
- To request and receive a copy of your medical records, and request that they be amended or corrected
- To be furnished health care services in accordance with federal and state regulations except as related to medically necessary services and the time frames set forth by federal and state regulations.
- To refuse any treatment, except as otherwise provided by law
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for your care
- If you are eligible for Medicare, to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
- To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained

- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- To know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research
- To receive information about Molina Healthcare, its services, its practitioners and providers and members' right and responsibilities
- To request and obtain information on any limits of your freedom of choice among network providers
- Free exercise of rights and the exercise of those rights do not adversely affect the way the Molina and its Providers treat you.
- To receive information about the structure and operation of Molina
- To make recommendations about Molina Healthcare's member rights and responsibilities policies
- To voice complaints or appeals about the organization or the care it provides
- To express grievance regarding any violation of your rights, through the grievance procedure of the health care provider or health care facility which served you and to the appropriate state licensing agency listed below

  Nevada Division of Medicaid

Your Responsibilities

- For 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.
- For the cost of unauthorized services obtained from non-participating providers.
- For reporting unexpected changes in your condition to the health care provider
- For reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you
- To follow the care plan that you have agreed on with your provider
- For keeping appointments and, when you are unable to do so for any reason, to notify the health care provider or healthcare facility

- For your actions if you refuse treatment or do not follow the health care provider's instructions
- For assuring that the financial obligations of your health care, if any, are fulfilled as promptly as possible
- For following health care facility rules and regulations affecting patient care and conduct
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To report 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)
- To formulate advance directives and to expect that those directives will be carried out

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.

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. local time 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, 1-866-606-3889
Or
Complete a report form online at:
MolinaHealthcare.alertline.com

Definitions:

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

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

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 An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

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 Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

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."

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; and
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
8329 W. Sunset Road
Las Vegas, NV 89113

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