MOLINA® HEALTHCARE

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

Molina Dual Options STAR+PLUS

Medicare-Medicaid Plan

2021 | Summary Of Benefits

Texas H8197-001

Serving Bexar, Dallas, El Paso, Harris, and Hidalgo Counties

Summary of Benefits 2021

Introduction

This document is a brief summary of the benefits and services covered by Molina Dual Options STAR+PLUS MMP. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Molina Dual Options STAR+PLUS MMP. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Disclaimers

This is a summary of health services covered by Molina Dual Options STAR+PLUS MMP for 2020. This is only a summary. Please read the *Member Handbook* for the full list of benefits.

- Members can call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time to ask for a hard copy of the Member Handbook. Members can also access the Member Handbook online by visiting www.MolinaHealthcare.com/Duals.
- Molina Dual Options STAR+PLUS Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.
- Under Molina Dual Options STAR+PLUS MMP you can get your Medicare and Texas Medicaid services in one health plan. A Molina Dual Options STAR+PLUS MMP Service Coordinator will help manage your health care needs.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the *Member Handbook*.
- Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., local time . The call is free.
- ATENCIÓN: Si usted habla español, los servicios de asistencia del idioma, sin costo, están disponibles para usted. Llame al (866) 856-8699, servicio TTY al 711, de lunes a viernes, de 8:00 a. m. a 8:00 p. m., hora local. La llamada es gratuita.
- You can get this document for free in other formats, such as large print, braille or audio. Call (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., local time. The call is free.
- You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request so you do not need to make separate requests each time we send you information. To get this document in a language other than English, please contact the State at (800) 252-8263, TTY: 711, Monday – Friday, 8 a.m. to 5 p.m., local time) to update your record with the preferred language.

- To get this document in an alternate format, please contact Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. A representative can help you make or change a standing request. You can also contact your Service Coordinator for help with standing requests.

B. Frequently Asked Questions

The following chart lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicare-Medicaid Plan?	A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Medicaid. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Service Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
What is a Molina Dual Options STAR+PLUS MMP Service Coordinator?	A Molina Dual Options STAR+PLUS MMP Service Coordinator is one main person for you to contact. This person helps manage all your providers and services and makes sure you get what you need.
What are long-term services and supports?	Long-term services and supports are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital.
Will you get the same Medicare and Texas Medicaid benefits in Molina Dual Options STAR+PLUS MMP that you get now? **(continued on the next page)**	You will get your covered Medicare and Texas Medicaid benefits directly from Molina Dual Options STAR+PLUS MMP. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. You will get almost all of your covered Medicare and Texas Medicaid benefits directly from Molina Dual Options STAR+PLUS MMP but you may get some benefits the same way you do now, outside of the plan. When you enroll in Molina Dual Options STAR+PLUS MMP, you and your service coordination team will work together to develop a Plan of Care to address your health and support needs. During this time, you can keep seeing your doctors and getting your current services for 90 days, or until

Frequently Asked Questions (FAQ)	Answers
Will you get the same Medicare and Texas Medicaid benefits in Molina Dual Options STAR+PLUS MMP that you get now? **(continued from previous page)**	your Plan of Care or Individual Service Plan (ISP) is complete. When you join our plan, if you are taking any Medicare Part D prescription drugs that Molina Dual Options STAR+PLUS MMP does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for Molina Dual Options STAR+PLUS MMP to cover your drug, if medically necessary.
Can you go to the same doctors you see now?	Often that is the case. If your providers (including doctors, therapists, and pharmacies) work with Molina Dual Options STAR+PLUS MMP and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." **You must use the providers in Molina Dual Options STAR+PLUS MMP's network.** • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of Molina Dual Options STAR+PLUS MMP's plan. • If you are past the 24th week of pregnancy, you can remain under the care of your current OB/GYN through your postpartum checkup within the first six (6) weeks of delivery. • Plan allows enrollees who at the time of enrollment have been diagnosed with and receiving treatment for a terminal illness to remain under the care of their current provider for covered services for up to nine months or until the Plan of Care and/or ISP are updated. • Plan allows enrollees receiving LTSS at the time of enrollment to remain under the care of their current provider for covered services for up to six months or until the Plan of Care and/or ISP are updated. To find out if your doctors are in the plan's network, call Member Services or read Molina Dual Options STAR+PLUS MMP's *Provider and Pharmacy Directory*. If Molina Dual Options STAR+PLUS MMP is new for you, you can continue seeing the doctors you go to now for at least up to 90 days or until a Health Risk Assessment is completed and your Plan of Care or ISP is updated and agreed upon by you.

Frequently Asked Questions (FAQ)	Answers
What happens if you need a service but no one in Molina Dual Options STAR+PLUS MMP's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, Molina Dual Options STAR+PLUS MMP will pay for the cost of an out-of-network provider.
Where is Molina Dual Options STAR+PLUS MMP available?	The service area for this plan includes: Bexar, Dallas, El Paso, Harris, and Hidalgo counties, Texas. You must live in one of these areas to join the plan.
Do you pay a monthly amount (also called a premium) under Molina Dual Options STAR+PLUS MMP?	You will not pay any monthly premiums to Molina Dual Options STAR+PLUS MMP for your health coverage.
What is prior authorization?	Prior authorization means that you must get approval from Molina Dual Options STAR+PLUS MMP before you can get a specific service or drug or see an out-of-network provider. Molina Dual Options STAR+PLUS MMP may not cover the service or drug if you don't get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. See Chapter 3 of the *Member Handbook* to learn more about prior authorization. See the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a prior authorization.
What is a referral?	A referral means that your primary care provider (PCP) must give you approval before you can see someone that is not your PCP or use other providers in the plan's network. If you don't get approval, Molina Dual Options STAR+PLUS MMP may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. See Chapter 3 of the *Member Handbook* to learn more about when you will need to get a referral from your PCP.

Frequently Asked Questions (FAQ)	Answers
Who should you contact if you have questions or need help?(continued on the next page)	**If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Molina Dual Options STAR+PLUS MMP Member Services:** **CALL** (866) 856-8699 Calls to this number are free. Monday - Friday, 8 a.m. to 8 p.m., local time Member Services also has free language interpreter services available for people who do not speak English. **TTY** 711 Calls to this number are free. Monday - Friday, 8 a.m. to 8 p.m., local time **If you have questions about your health, please call the Nurse Advice Call line:** **CALL** (888) 275-8750 Calls to this number are free. 24 hours a day, 7 days a week **TTY** 711 Calls to this number are free.24 hours a day, 7 days a week

Frequently Asked Questions (FAQ)	Answers
Who should you contact if you have questions or need help?(continued from previous page)	**If you need immediate behavioral health services, please call the Behavioral Health Crisis Line:** **CALL** (800) 818-5837 Calls to this number are free. 24 hours a day, 7 days a week **TTY** 711 for English and Spanish Calls to this number are free. 24 hours a day, 7 days a week

C. Overview of Services

The following chart is a quick overview of what services you may need, your costs and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want to see a doctor	Visits to treat an injury or illness	$0	
	Wellness visits, such as a physical	$0	Annual Wellness visit every 12 months.
	Specialist care	$0	Please see your primary care physician for a referral or help getting prior authorization first before going to see a specialist. All female members will have direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. Members with Special Health Care Needs have access to specialists as appropriate for the member's condition and identified needs.
	Care to keep you from getting sick, such as flu shots	$0	
	"Welcome to Medicare" preventive visit (one time only)	$0	
You need medical tests (This service is continued on the next page)	Lab tests, such as blood work	$0	Authorization rules may apply for certain tests.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests (continued)			Outpatient Lab services do not require prior authorization.
	X-rays or other pictures, such as CAT scans	$0	Authorization rules may apply. Outpatient X-ray services do not require prior authorization.
	Screening tests, such as tests to check for cancer	$0	Authorization rules may apply.
You need drugs to treat your illness or condition (This service is continued on the next page)	Generic drugs (no brand name)	$0 for a 31-day supply	There may be limitations on the types of drugs covered. Please see Molina Dual Options STAR+PLUS MMP's *List of Covered Drugs* (Drug List) for more information. A 90-day supply is available at retail and mail order pharmacy at no additional cost. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. There may be certain drugs that are limited to a 31-day supply. Some drugs have quantity limits. Your provider must get prior authorization from Molina Dual Options STAR+PLUS MMP for certain drugs.
	Brand name drugs	$0 for a 31-day supply	There may be limitations on the types of drugs covered. Please see Molina Dual

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			Options STAR+PLUS MMP's *List of Covered Drugs* (Drug List) for more information. A 90-day supply is available at retail and mail order pharmacy at no additional cost. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. There may be certain drugs that are limited to a 31-day supply. Some drugs have quantity limits. Your provider must get prior authorization from Molina Dual Options STAR+PLUS MMP for certain drugs.
	Non-Medicare Rx/Over-the-counter drugs	$0	There may be limitations on the types of drugs covered. Please see Molina Dual Options STAR+PLUS MMP's *List of Covered Drugs* (Drug List) for more information. You will have access to a 72-hour supply of emergency, Medicaid prescriptions from network pharmacies when a medication is needed without delay and prior authorization (PA) is not available.
	Medicare Part B prescription drugs	$0	Authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			Part B drugs include drugs given by your doctor in his or her office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs.
	Over-The-Counter (OTC) items	$0	We cover non-prescription over-the-counter (OTC) products like vitamins, sunscreen, pain relievers, cough/cold medicine, and bandages. You get $120 every 3 months that you can spend on plan-approved items. Your quarterly allowance becomes available to use in January, April, July and October. Any dollar amount that you don't use will carry over into the next 3 months. Be sure to spend all of it before the end of the year because it expires at the end of the calendar year. You do not need a prescription from your doctor to get OTC items. When you are in a nursing facility, you will not be able to use this OTC benefit. During this time, you will only have access to covered prescription drugs found in the plan's Formulary (including Tier 3 non-Medicare Rx/OTC drugs). Once we learn that you are no longer in

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			a nursing facility, we will mail you a replacement / new OTC Product Catalog so that you can once again order non-prescription plan-approved OTC items from this catalog.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Authorization rules may apply.
You need emergency care	Emergency room services	$0	You may get emergency room services whenever you need it, anywhere in the United States or its territories, without prior authorization. Not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details.
	Ambulance services	$0	Authorization is not required for emergency transportation. Prior authorization rules may apply for non-emergency Ambulance services.
	Urgent care	$0	You may get urgent care services whenever you need it, anywhere in the United States or its territories, without prior authorization. Not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Hospital stay	$0	Authorization rules may apply. Our plan covers an additional 30 days inpatient hospital stay per benefit period in addition to Medicare's coverage for a total of 120 days.
	Doctor or surgeon care	$0	Authorization rules may apply.
You need help getting better or have special health needs	Rehabilitation services	$0	Authorization rules may apply.
	Medical equipment for home care	$0	Authorization rules may apply.
	Skilled nursing care	$0	Authorization rules may apply. Our plan covers 100 days in a Skilled Nursing Facility (SNF). Long term Nursing Facility stays are unlimited based upon medical necessity as established by the Health and Human Services Commission (HHSC).
You need eye care	Eye exams	$0	The Medicaid-covered routine eye exam is only available once every 24 months. The Plan covered flexible eye exam benefit is available for the interim year.
	Glasses or contact lenses	$0	Our plan will pay for one pair of glasses or contact lenses every two years. Our plan covers up to $200 for one (1) pair of frames, eyeglass lenses or contacts every 2 years.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (This service is continued on the next page)	Dental check-ups	$0	Preventive dental services for Non-Waiver members living in the community: • Cleaning • Dental x-rays • Fluoride treatment • Oral exam Our plan also covers comprehensive dental services. Authorization rules may apply for some comprehensive dental services. Contact the plan for more details. Our plan pays up to $1,000 every year for preventive and comprehensive services. This annual limit is for all dental services combined: preventive, comprehensive and dentures. Members in a Nursing Facility are eligible for only the following dental benefits: Up to $250 per year for dental check-ups, x-rays, and cleaning for Members age 21 and older. Dental Services for waiver members (The annual cost cap of this service is $5,000 per waiver plan year. Exceptions to the $5,000 cap may be made up to an

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)			additional $5,000 per waiver plan year when the services of an oral surgeon are required.)
You need hearing/auditory services	Hearing screenings	$0	
	Hearing aids	$0	Authorization rules may apply. Limit: One hearing aid every 5 years from the month it is dispensed, either the left or the right may be reimbursed but not both in the same 5 year period.
You have a chronic condition, such as diabetes or heart disease	Services to help manage your disease	$0	Coverage includes self-management training and disease management program for diabetics.
	Diabetes supplies and services	$0	Authorization rules may apply. Benefit includes diabetes monitoring supplies and therapeutic shoes or inserts.
You have a mental health condition	Mental or behavioral health services	$0	Outpatient group therapy visit. Outpatient individual therapy visit.
You have a substance abuse problem	Substance abuse services	$0	Outpatient group therapy visit. Outpatient individual therapy visit.
You need long-term mental health services	Inpatient care for people who need mental health care	$0	Authorization rules may apply. Our plan covers an unlimited number of days for an inpatient hospital stay.
You need durable medical equipment (DME) (This service is continued on the next page)	Wheelchairs	$0	Authorization rules may apply.
	Nebulizers	$0	Authorization rules may apply.
	Crutches	$0	Authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) (continued)	Walkers	$0	Authorization rules may apply.
	Oxygen equipment and supplies	$0	Authorization rules may apply.
You need help living at home	Meals brought to your home	$0	Authorization rules may apply.
	Home services, such as cleaning or housekeeping	$0	Authorization rules may apply.
	Changes to your home, such as ramps and wheelchair access	$0	Authorization rules may apply. Subject to a $7500 lifetime limit and $300 annually for repairs. This service is provided only to members enrolled in the HCBS STAR+PLUS Waiver.
	Personal care assistant (You may be able to employ your own assistant. Call Member Services for more information.)	$0	Authorization rules may apply.
	Training to help you get paid or unpaid jobs	$0	Authorization rules may apply. This service is provided only to members enrolled in the HCBS STAR+PLUS Waiver.
	Home health care services	$0	Authorization rules may apply. The plan offers additional hours of care for Home Health Services.
	Services to help you live on your own	$0	Authorization rules may apply.
	Adult day services or other support services	$0	Authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Assisted living or other housing services	$0	Authorization rules may apply. This service is provided only to members enrolled in the HCBS STAR+PLUS Waiver.
	Nursing home care	$0	Authorization rules may apply. Long term Nursing Facility stays are unlimited based upon medical necessity as established by the Health and Human Services Commission (HHSC).
Your caregiver needs some time off	Respite care	$0	Up to 30 days or 720 hours of Respite services for eligible members enrolled with HCBS STAR+PLUS waiver. Authorization Required. Plan covers up to 8 hours of Respite per calendar year for STAR+PLUS members who are age 21 and older who are not enrolled in the HCBS STAR+PLUS waiver. Authorization required.
Additional Services (This service is continued on the next page)	Meal Benefit	$0	Qualifying members get an extra meal benefit of 56 meals delivered over 4 weeks, based on your needs.
	Podiatry Services	$0	Up to 12 visits per year for routine foot care.
	Prosthetic/Medical Supplies	$0	Authorization rules may apply.
	Dialysis Services	$0	
	Partial Hospitalization	$0	Authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional Services (continued)	Ambulatory Surgical Center (ASC) Services	$0	Authorization rules may apply.
	Outpatient Blood Services	$0	
	Kidney Disease Education	$0	
	Skid Proof Socks	$0	One time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Personal Blanket	$0	One time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Accessory Tote Bag	$0	One time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Reacher/Grabber	$0	One time for Nursing Facility Members every 2 years and will be delivered to the member's nursing facility within 30 days of confirmed enrollment.
	Large Print Digital Clock	$0	One time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Personal Emergency Response System (PERS)	$0	Authorization rules may apply.
	Weight Watchers program	$0	
	Nutritional Counseling over the phone	$0	
	Smoking Cessation	$0	
	Community First Choice Services (CFC)	$0	Provided for those who qualify based on level of care and medical necessity.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional Services (continued)			• Personal Assistance Services (PAS); • Habilitation (acquisition, maintenance and enhancement of skills); • Emergency Response Services; and • Support Management Authorization rules may apply.
	Outpatient Hospital Services	$0	Authorization rules may apply.
	Enhanced Disease Management	$0	
	Counseling Services	$0	

D. Services covered outside of Molina Dual Options STAR+PLUS MMP

This is not a complete list. Call Member Services to find out about other services not covered by Molina Dual Options STAR+PLUS MMP but available through Medicare or Texas Medicaid.

Other services covered by Medicare or Texas Medicaid	Your costs
Some hospice care services	$0
Nonemergency medical transportation services	$0
Pre-admission screening and resident review (PASRR)	$0
Medicare-covered acupuncture for chronic lower back pain	$0

E. Services not covered by Molina Dual Options STAR+PLUS MMP, Medicare, or Texas Medicaid

This is not a complete list. Call Member Services or read the *Member Handbook* to find out about other excluded services.

Services not covered by Molina Dual Options STAR+PLUS MMP, Medicare, or Texas Medicaid	
Alternative Therapies	Worldwide Emergency Coverage

F. Your rights as a member of the plan

As a member of Molina Dual Options STAR+PLUS MMP, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
  - Get information in other formats (e.g., large print, braille, audio)
  - Be free from any form of physical restraint or seclusion
  - Not be billed by network providers
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a format you can understand. These rights include getting information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and care managers
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a Primary Care Provider (PCP) and you can change your PCP at any time during the year
  - See a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered
  - Refuse treatment, even if your doctor advises against it
  - Stop taking medicine
  - Ask for a second opinion. Molina Dual Options STAR+PLUS MMP will pay for the cost of your second opinion visit.
- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your doctors and your health plan

- **You have the right to seek emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior approval in an emergency
  - See an out of network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private
- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - File a complaint or grievance against us or our providers
  - Ask for a state fair hearing
  - Get a detailed reason for why services were denied

For more information about your rights, you can read the Molina Dual Options STAR+PLUS MMP *Member Handbook*. If you have questions, you can also call Molina Dual Options STAR+PLUS MMP Member Services.

G. How to file a complaint or appeal a denied service

If you have a complaint or think Molina Dual Options STAR+PLUS MMP should cover something we denied, call Molina Dual Options STAR+PLUS MMP at (866) 856-8699. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the Molina Dual Options STAR+PLUS MMP *Member Handbook*. You can also call Molina Dual Options STAR+PLUS MMP Member Services.

Or you can write to Molina Healthcare

Attn: Grievance and Appeals
P.O. Box 22816
Long Beach, CA. 90801-9977
FAX: 562-499-0610

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at Molina Dual Options STAR+PLUS MMP Member Services. Phone numbers are on the cover of this summary.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

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

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

I. Ways to report fraud, waste, or abuse:

- Call the OIG Hotline at 1-800-436-6184;
- Visit oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  - MCO's name;

- MCO's office/director address; and
- MCO's toll-free number.

I1. To report fraud, waste, or abuse, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.), include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Texas Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the fraud, waste, or abuse
- You may also call Molina Healthcare Alertline (Fraud and Abuse Hotline) at (866) 606-3889, TTY: 711.