2025

Summary of Benefits

Molina Dual Options STAR+PLUS MMP

Texas H8197-002-002

Effective January 1 through December 31, 2025

MOLINA® HEALTHCARE

TEXAS Medicare Medicaid PLAN

Your Health Plan ★ Your Choice

TEXAS Health and Human Services

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Summary of Benefits 2025

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*.

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A. Disclaimers

This is a summary of health services covered by Molina Dual Options STAR+PLUS MMP for 2025. This is only a summary. Please read the *Member Handbook* for the full list of benefits.

- The 2025 Member Handbook is always available on our website at MolinaHealthcare.com/Duals. You may also call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time to ask us to mail you a Member Handbook.
- Molina Dual Options STAR+PLUS MMP 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*.
- 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.
- To request your preferred language other than English and/or alternate format, call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.
- We will maintain a record of our member's preferred language and/or format preferences, and we will keep this information as a standing request for future mailings and communications. This will ensure that our members will not have to make a separate request each time.
- To change a standing request, call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

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 I get the same Medicare and Texas Medicaid benefits in Molina Dual Options STAR+PLUS MMP that I get now?	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 using your doctors and getting your current services for 90 days, or until 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 I use the same doctors I use now? (continued on the next page)	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 using them.

Frequently Asked Questions (FAQ)	Answers
Can I use the same doctors I use now? (continued)	• 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* on the plan's website at MolinaHealthcare.com/Duals. If Molina Dual Options STAR+PLUS MMP is new for you, you can continue using the doctors you use 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.
What happens if I 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 and Harris Counties, Texas. You must live in one of these areas to join the plan.
Do I 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 (PA)? (continued on the next page)	PA means that you must get approval from Molina Dual Options STAR+PLUS MMP before you can get a specific service or drug or use an out-of-network provider. Molina Dual Options STAR+PLUS MMP may not cover the service or drug if you don't get approval.

Frequently Asked Questions (FAQ)	Answers
What is prior authorization (PA)? (continued)	If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. Refer to Chapter 3 of the *Member Handbook* to learn more about PA. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a PA.
What is a referral?	A referral means that your primary care provider (PCP) must give you approval before you can use 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 use certain specialists, such as women's health specialists. Refer to Chapter 3 of the *Member Handbook* to learn more about when you will need to get a referral from your PCP.
Do I pay a deductible?	No. You do not pay deductibles in Molina Dual Options STAR+PLUS MMP.
Who should I contact if I 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.

Frequently Asked Questions (FAQ)	Answers
Who should I contact if I have questions or need help?(continued from the previous page)	**TTY** 711 Calls to this number are free. 24 hours a day, 7 days a week.
Who should you contact if you have questions or need help?	**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 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**	Prior authorization rules may apply for certain tests. Outpatient Lab services do not require prior authorization.
	X-rays or other pictures, such as CAT scans	**$0**	Outpatient X-ray services do not require prior authorization. Prior 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 medical tests (continued)	Screening tests, such as tests to check for cancer	**$0**	Prior 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 refer to Molina Dual Options STAR+PLUS MMP's List of Covered Drugs (Drug List) for more information. A 100-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 refer to Molina Dual Options STAR+PLUS MMP's List of Covered Drugs (Drug List) for more information. A 100-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.

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)			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 refer to 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**	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. Prior authorization rules may apply.
	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 not carry over into the next 3 months. Be sure to spend all of it before the end of the pay period because it expires. You do not need a prescription from your doctor to get OTC items.

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)			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 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.
	Step Therapy	**$0**	Step therapy may be required for certain drugs.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	**$0**	Prior 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 United States and its territories except under limited circumstances. Contact plan for details.
	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 United States 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**	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. Prior authorization rules may apply.
	Doctor or surgeon care	**$0**	Prior authorization rules may apply.
You need help getting better or have special health needs	Rehabilitation services	**$0**	Prior authorization rules may apply.
	Medical equipment for home care	**$0**	Prior authorization rules may apply.
	Skilled nursing care	**$0**	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). Prior authorization rules may apply.
You need eye care	Eye exams	**$0**	The Medicaid-covered routine eye exam is only available once every 24 months. The plan covers routine eye exam every 12 months.
	Glasses or contact lenses	**$0**	Our plan will pay for one pair of glasses or contact lenses every year. Our plan additionally covers up to $300 for one (1) pair of frames, eyeglass lenses or contacts every year.

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	Dental check-ups	**$0**	Preventive dental services for STAR+PLUS non-waiver Members living in the community: • Cleaning • Dental x-rays • Fluoride treatment • Oral exam Our plan pays for preventive and comprehensive care services up to a $2,000 annual limit for STAR+PLUS non-waiver Members in the Community. Prior authorization rules may apply. Members in a Nursing Facility are eligible for only the following dental benefits: Up to $2,000 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 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**	The plan will pay for hearing aids for one ear every five years. Plan covers up to an additional $2,000 every year for hearing aids above the Medicaid provided benefit. Benefits and limits as described in the Texas Medicaid Provider Procedures Manual

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
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**	Benefit includes diabetes monitoring supplies and therapeutic shoes or inserts. Prior authorization rules may apply.
You have a mental health condition	Mental or behavioral health services	**$0**	Outpatient group therapy visit. Outpatient individual therapy visit. Prior authorization rules may apply.
You have a substance abuse problem	Substance abuse services	**$0**	Outpatient group therapy visit. Outpatient individual therapy visit. Prior authorization rules may apply.
You need long-term mental health services	Inpatient care for people who need mental health care	**$0**	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules may apply.
You need durable medical equipment (DME)	Wheelchairs	**$0**	Prior authorization rules may apply.
	Nebulizers	**$0**	Prior authorization rules may apply.
	Crutches	**$0**	Prior authorization rules may apply.
	Walkers	**$0**	Prior authorization rules may apply.
	Oxygen equipment and supplies	**$0**	Prior authorization rules may apply.
You need help living at home (This service is continued on the next page)	Meals brought to your home	**$0**	Prior authorization rules may apply.
	Home services, such as cleaning or housekeeping	**$0**	Prior authorization rules may apply.
	Changes to your home, such as ramps and wheelchair access	**$0**	Subject to a $7,500 lifetime limit and $300 annually for repairs. This service is provided only to members enrolled in the HCBS STAR+PLUS Waiver. Prior authorization rules may apply.
	Personal care assistant (You may be able to employ your own assistant. Call	**$0**	Prior 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 help living at home (continued)	Member Services for more information.)		
	Training to help you get paid or unpaid jobs	**$0**	This service is provided only to members enrolled in the HCBS STAR+PLUS Waiver. Prior authorization rules may apply.
	Home health care services	**$0**	The plan offers additional hours of care for Home Health Services. Prior authorization rules may apply.
	Services to help you live on your own	**$0**	Prior authorization rules may apply.
	Adult day services or other support services	**$0**	Prior authorization rules may apply.
You need a place to live with people available to help you	Assisted living or other housing services	**$0**	This service is provided only to members enrolled in the HCBS STAR+PLUS Waiver. Prior authorization rules may apply.
	Nursing home care	**$0**	Long term Nursing Facility stays are unlimited based upon medical necessity as established by the Health and Human Services Commission (HHSC). Prior authorization rules may apply.
Your caregiver needs some time off	Respite care	**$0**	Up to 30 visits of Respite services for eligible members enrolled with HCBS STAR+PLUS waiver. 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. Prior authorization Required.
You need transportation	Ambulance services	**$0**	Prior authorization is not required for emergency transportation.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
			Prior authorization rules may apply for non-emergency Ambulance services.
	Nonemergency Medical Transportation (NEMT) services to the doctor, dentist, hospital, pharmacy, and other places you get healthy care services	**$0**	Refer to Chapters 3 and 4 of the Member Handbook to learn more about NEMT services.
Additional covered Service (This service is continued on the next page)	Accessory Tote Bag	**$0**	Available one time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Ambulatory Surgical Center (ASC) Services	**$0**	Prior authorization rules may apply.
	Community First Choice Services (CFC):	**$0**	Provided for those who qualify based on level of care and medical necessity. • Personal Assistance Services (PAS); • Habilitation (acquisition, maintenance and enhancement of skills); • Emergency Response Services; and • Support Management Prior authorization rules may apply
	Counseling Services	**$0**	
	Dialysis Services	**$0**	
	Enhanced Disease Management	**$0**	
	Fitness Benefit	**$0**	You get a fitness center membership to participating fitness centers. If you are unable to visit a fitness center or prefer to also work out from home, you can select a Home Fitness kit.
	Kidney Disease Education	**$0**	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered Service (continued)	Large Print Digital Clock	**$0**	Available one time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Meal Benefit	**$0**	Qualifying members get an extra meal benefit of 56 meals delivered over 4 weeks, based on your needs.
	Nutritional Counseling over the phone	**$0**	
	Outpatient Blood Services	**$0**	Prior authorization rules may apply.
	Outpatient Hospital Services	**$0**	
	Partial Hospitalization	**$0**	Prior authorization rules may apply.
	Personal Blanket	**$0**	Available one time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Personal Emergency Response System (PERS)	**$0**	Prior authorization rules may apply.
	Podiatry Services	**$0**	Up to 12 visits per year for routine foot care. Prior authorization rules may apply.
	Prosthetic/Medical Supplies	**$0**	Prior authorization rules may apply.
	Skid Proof Socks	**$0**	Available one time for new Nursing Facility Members within 30 days of confirmed enrollment.
	Smoking Cessation	**$0**	
	Weight Watchers program	**$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
Pre-admission screening and resident review (PASRR)	$0
Medicare-covered acupuncture for chronic lower back pain	$0 Prior authorization rules may apply.
Medicare-covered chiropractic	$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 change your PCP at any time during the year
  - use 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 emergency and urgent care when you need it.** This means you have the right to:
  - get emergency services without prior approval (PA) in an emergency
  - use 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, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. 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 they have to get benefits.

I. Ways to report fraud, waste, or abuse

- Call the OIG Hotline at 1-800-436-6184;
- Visit oig.hhs.texas.gov/ and click "Report 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.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter, just call us at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time. Someone who speaks English can help you. This is a free service.

SPANISH

Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (866) 856-8699, TTY: 711, de lunes a viernes, de 8 a. m. a 8 p. m., hora local. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

TRADITIONAL CHINESE

我們有免費的口譯員服務，可回答您對於我們健康或藥物計劃的任何問題。若需要口譯員，請撥打 (866) 856-8699，TTY: 711，服務時間為當地時間的週一到週五的上午8 點至晚上8 點。能說中文的人士會為您提供協助。這是免費的服務。

SIMPLIFIED CHINESE

如果您对我们的健康计划或药品计划有任何疑问，我们可以提供免费的口译服务解答您的疑问。若要获得口译服务，请致电我们，电话：(866) 856-8699，TTY: 711，周一至周五提供服务，服务时间为当地时间上午8 点至晚上8 点。说中文的人士会帮助您。这是免费服务。

TAGALOG

Mayroon kaming libreng serbisyo ng tagapagsalin para sagutin ang anumang katanungan na maaaring mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para makakuha ng tagapagsalin, tawagan lang kami sa numerong (866) 856-8699, TTY: 711, Lunes – Biyernes, 8 a.m. hanggang 8 p.m. lokal na oras. May makakatulong sa inyo na nagsasalita ng Tagalog. Isa itong libreng serbisyo.

FRENCH

Nous assurons gracieusement des services d'interprétariat afin de répondre à toute question que vous pourriez avoir sur votre santé ou plan de traitement. Pour obtenir l'assistance d'un interprète, il suffit de nous appeler au (866) 856-8699, TTY : 711, du lundi au vendredi de 8 h à 20 h (heure locale). Une personne parlant français pourra vous assister. Ce service est proposé sans frais.

VIETNAMESE

Chúng tôi có các dịch vụ thông dịch miễn phí để trả lời các câu hỏi của quý vị về chương trình sức khỏe hoặc chương trình thuốc của chúng tôi. Để có thông dịch viên, hãy gọi cho chúng tôi theo số (866) 856-8699, TTY: 711, Thứ Hai – Thứ Sáu, 8 giờ sáng đến 8 giờ tối, giờ địa phương. Sẽ có nhân viên nói tiếng Việt trợ giúp quý vị. Đây là dịch vụ miễn phí.

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GERMAN

Wir bieten Ihnen kostenlose Dolmetscherdienste, um Ihre Fragen, die Sie möglicherweise zu unseren Gesundheits- oder Arzneimittelleistungen haben, zu beantworten. Wenn Sie mit einem Dolmetscher sprechen möchten, rufen Sie uns einfach an unter (866) 856-8699, TTY: 711, Montag – Freitag, 8:00 Uhr bis 20:00 Uhr (Ortszeit). Jemand, der Deutsch spricht, hilft Ihnen gerne weiter. Dies ist ein kostenloser Dienst.

KOREAN

당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (866) 856-8699번, TTY: 711번으로 월요일~금요일 오전 8시~오후 8시 (현지 시간)에 문의해 주십시오. 한국어를 하는 담당자가 도와드릴 것입니다. 이 서비스는 무료로 운영됩니다.

RUSSIAN

Получить ответы на вопросы о нашем медицинском страховом плане или о плане, покрывающем лекарства по рецепту, вам бесплатно помогут наши устные переводчики. Просто позвоните нам по номеру (866) 856-8699 (TTY: 711). Линия работает с понедельника по пятницу с 8:00 до 20:00 по местному времени. Вам бесплатно поможет русскоязычный сотрудник.

ARABIC

نوفر خدمات الترجمة الفورية المجانية للإجابة على أي أسئلة قد تراودك حول الخطة الصحية أو خطة الأدوية لدين ا. للحصول على مترجم فوري، كل ما عليك هو الاتصال بنا على الرقم 8699-856 (866)، وبالنسبة إلى مستخدمي أجهزة الهواتف النصية (TTY) يرجى االتصال على الرقم 711 من الاثنين إلى الجمعة، من الساعة 8 صباح اً حتى الساعة 8 مساءً ، بالتوقيت المحلي، ويمكن لشخص يتحدث اللغة العربية مساعدتك. تقدم هذه الخدمة مجاناً.

ITALIAN

È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per ottenere un interprete, contattare il numero (866) 856-8699, TTY: 711, dal lunedì al venerdì, dalle 8:00 alle 20:00 ora locale. Un nostro incaricato che parla italiano fornirà l'assistenza necessaria. È un servizio gratuito.

PORTUGUESE

Dispomos de serviços de interpretação gratuitos para responder a possíveis dúvidas que possa ter sobre o nosso plano de saúde ou plano para medicamentos. Para falar com um intérprete, ligue (866) 856-8699, TTY: 711, segunda – sexta, 08h00 até 20h00 horário local. Alguém que fala português pode ajudá-lo. Este é um serviço gratuito.

FRENCH CREOLE

Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan (866) 856-8699, TTY: 711, Lendi – Vandredi, 8 a.m. rive 8 p.m. lè lokal. Yon moun ki pale kreyòl ayisyen ka ede w. Sa a se yon sèvis gratis.

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POLISH

Oferujemy bezpłatne usługi tłumacza, który pomoże uzyskać odpowiedzi na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub dawkowania leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić do nas pod numer (866) 856-8699, TTY: 711. Jest on dostępny od poniedziałku do piątku w godzinach od 8:00 do 20:00 czasu lokalnego. Pomocy udzieli osoba mówiąca po polsku. Ta usługa jest bezpłatna.

HINDI

हमारी स्वास्थ्य या दवा योजना के बारे में अगर आपके कुछ सवाल हैं, तो उनके जवाब देने के लिए हमारे पास निःशुल्क दुभाषिया सेवाएँ उपलब्ध हैं। दुभाषिया पाने के लिए, हमें सोमवार – शुक्रवार, स्थानीय समयानुसार सुबह 8 बजे से रात 8 बजे तक (866) 856-8699, TTY: 711 पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

JAPANESE

弊社の医療保険プランや処方薬プランについてお問い合わせいただく際に無料の通訳サービスをご利用いただけます。通訳をご希望の場合は、(866) 856-8699（TTY：711）までお電話にてご連絡くださいい（営業時間：月～金、午前8時～午後8時）。日本語を話せるスタッフがお手伝いいたします。このサービスは無料でご利用いただけます。

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