Welcome to the Molina family.

January 2012
Washington

Basic Health

Your Extended Family.

If the enclosed information is not your primary language, or you need this in another format, call Molina Healthcare Member Services at 1-800-869-7165.
ENG

Yog cov ntaub ntawv uas nyob hauv lub hnab no tsis yog koj yam lus, lossis koj xav tau cov ntaub ntawv no sau ua lwm yam lus, hu rau cov neeg ua haujlwm hauv Molina Healthcare Member Services ntawm 1-800-869-7165.
HMG

Afai e le o aofia lau gagana muamua e fa'amalamalama ai mata'upu nei, pe e te finagalo i se isi fa'atulagana, vala'au le Galuega Tautua Fa'asoifua-maloloina a Molina mo Sui 'Auai i le 1-800-869-7165.
SAM

Если прилагаемая информация не на вашем родном языке либо она необходима вам в другом формате, пожалуйста, позвоните в Отдел обслуживания клиентов компании Molina Healthcare по телефону 1-800-869-7165.
RUS

Якщо прикладена інформація не на вашій рідній мові або вона потрібна вам в іншому форматі, будь ласка, зателефонуйте у Відділ обслуговування клієнтів компанії Molina Healthcare за номером 1-800-869-7165.
UKR

동봉한 정보가 모국어가 아니거나 이 정보를 다른 형식(예: 점자, 대형 인쇄판)으로 받길 원하시면 Molina Healthcare 고객 서비스부, 1-800-869-7165로 전화하십시오.
KOR

Dacă informațiile alăturate nu sunt în limba dumneavoastră principală (maternă) sau dacă aveți nevoie de aceste informații în alt format, luați legătura cu Serviciul pentru Membri de la Molina Healthcare la 1-800-869-7165.
ROM

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AMH

ຖ້າຂໍ້ມູນທີ່ຕິດຄັດມາພ້ອມນີ້ບໍ່ເປັນພາສາພື້ນເມືອງຂອງທ່ານ, ກະລຸນາໂທຫາຜູ້ຕົວແທນ ການບໍລິການລູກຄ້າ Molina Healthcare ຢູ່ທີ່ 1-800-869-7165.
LAO

እዚ ቀጺሉ ተዋሂቡ ዘሎ ሓበሬታ እንተድኣ ብቋንቋኹን ዘይተጻሕፈ ኮይኑ ወይ ብኻልእ ፎርማ ዝተዳለወ እንተደሊኹም፣ ናብ ሞሊና፣ ናይ ክንክን ጥዕና ናይ ዓማዊል ኣገልግሎት ወኪል ብቁጽሪ 1-800-869-7165 ደውሉ።
TIG

Si la informacion adjunta no esta en su idioma principal o si la necesita en otro formato, llame a Servicios a los Miembros de Molina Healthcare al 1-800-869-7165.
SPA

Nếu chi tiết đính kèm không phải là ngôn ngữ chính của quý vị, hoặc quý vị cần những chi tiết này bằng một hình thức khác, xin gọi cho Ban Phục Vụ Khách Hàng của Molina Healthcare số 1-800-869-7165.
VTN

如果所附資訊不是你的第一語言，或者你需要以其他版本格式提供所附資訊，請電Molina保健計畫成員服務處：1-800-869-7165。
TCH

បើសិនជាពត៌មានដែលបានដាក់ភ្ជាប់មកជាមួយនេះ មិនមែនជាភាសារបស់អ្នកទេ ឬបើអ្នកត្រូវការពត៌មាននេះជាទំរង់ផ្សេងទៀត សូមទូរស័ព្ទទៅផ្នែកបំរើសមាជិក Molina Healthcare តាមលេខ 1-800-869-7165 ។
KHM

ਜੇ ਨਾਲ ਨੱਥੀ ਜਾਣਕਾਰੀ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਨਹੀਂ ਹੈ, ਜਾਂ ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿੱਚ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਮੋਲੀਨਾ ਹੈਲਥਕੇਅਰ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੂੰ 1-800-869-7165 'ਤੇ ਫੋਨ ਕਰੋ।
PUNJ

यदि संलग्न जानकारी आपकी अपनी भाषा में नहीं है, या यदि आपको यह किसी और फॉर्मेट में चाहिए, तो मोलिना हैल्थकेअर मेंबर सर्विसिस को 1-800-869-7165 पर फोन करें।
HIN

If you need the enclosed information in another format call Molina Healthcare Member Services Department at 1-800-869-7165.

Welcome to Molina Healthcare of Washington

Thank you for choosing Molina Healthcare as your Basic Health managed care plan. You have two Member handbooks – this one from Molina Healthcare and another one from Basic Health. The State's Basic Health Member Handbook is available online only at www.basichealth.hca.wa.gov. You may request a hard copy by calling (800) 660-9840. Please read both of these books to understand your Benefits. For some plan definitions and Benefit limits, we will refer you to the State's Basic Health Member Handbook. If you have questions or need help understanding this book, please call Molina Healthcare Member Services at **(800) 869-7165.**

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Introduction

Molina Healthcare is your Basic Health managed care plan

Molina Healthcare contracts with the Health Care Authority (HCA) to be a managed care plan for people on Basic Health. A managed care plan contracts with providers to care for your medical needs.

Molina Healthcare Member Services

We are open to help you Monday through Friday from 8:00 a.m. until 5:00 p.m. at (800) 869-7165 to answer your questions and concerns such as:

- Finding a Primary Care Provider (PCP) in your area
- Changing your PCP
- Benefit information
- Authorization or Denial information

Molina Healthcare cannot give you direct health advice. When you have questions about your healthcare, call your PCP or our 24-hour Nurse Advice Line at (888) 275-8750.

We can help you if you do not speak English. If you need help in another language, choose your language at (800) 869-7165. If your language is not listed, we will use an interpreter. This service is at no cost to you. If you are hearing impaired, please use TTY at (877) 665-4629.

This handbook and other information are on our website at **www.MolinaHealthcare.com.**

How do I get the healthcare I need?

Whether you are a regular Basic Health Member or part of the Health Coverage Tax Credit (HCTC) program, this handbook applies to you. Please see the Maternity Benefits section for exceptions.

To get the healthcare you need, you must use providers who have contracts with Molina Healthcare for Basic Health. Any exceptions require Prior Approval by Molina Healthcare.

You get most of your healthcare from your PCP (see “Primary Care Provider” - page 6). If you need specialty care, your PCP will Refer you to a Specialist who has a contract with Molina Healthcare. Your PCP must approve your specialty care, except emergencies, mental health and women’s healthcare. If you need a list of Contracted Providers or you want to know about Molina Healthcare’s Service Area, call Member Services at (800) 869-7165 or go to our website at **www.MolinaHealthcare.com**.

Where do I get care?

In most cases you will get your healthcare from your PCP (see “Primary Care Provider” – page 6). You also get care from providers (pharmacies, hospitals, Specialists, etc.) who have contracts with Molina Healthcare. You need to get your care in Molina Healthcare’s Service Area (see “Definitions”- page 33). If you get care outside your county (your Service Area) or from a provider who does not have a contract with Molina Healthcare, you may have to pay for that care.

Exceptions:

- Emergencies (see "How do I get Emergency Care or Urgent Care?" - page 8 and "What if I need care while away from home?" - page 9)
- When Molina Healthcare Pre-Authorizes a visit to a provider who does not have a contract with Molina Healthcare

No Waiting Period for Pre-existing Conditions

Beginning January 1, 2012 there is no waiting period for pre-existing conditions.

ID Cards

You should have an ID card for each family member on Molina Healthcare. Always carry your ID card with you and show it when you get medical or pharmacy services.

How do I stay enrolled in this program?

Basic Health is required by Washington State law to verify Member income and eligibility for the Basic Health program. This is called recertification. Basic Health recertifies all Member accounts once a year.

When selected for recertification, Members need to complete and return all forms they receive along with required documentation showing proof of income and Washington State residency. You need to respond to recertification requests by the due date or you may lose your Basic Health coverage. If you are disenrolled you will not be allowed to re-enroll for at least 12 months and may have to wait for space to become available.

If you have questions about recertification, please call Basic Health at (800) 660-9840.

What if I do not speak English?

We have many bilingual staff in Member Services. When you call us, you will hear a phone prompt for Members who speak Russian, Spanish or Vietnamese.

If we do not speak your language, we can use an interpreter.

Getting Care

Primary Care Provider (PCP)

You must get most of your healthcare from your PCP (OB/GYN is a Specialist and cannot be your PCP). Your PCP (Physician, Nurse Practitioner, Physician Assistant, etc.) provides care for common problems and any health or disease screenings you need. Your PCP's name and phone number are on your ID card. If you need to see a Specialist, your PCP will Refer you.

How do I choose a PCP?

When choosing a PCP you may want to think about specialty (Family Practice, Pediatrics, Internal Medicine, etc.), language, location and gender. Call Member Services at (800) 869-7165 and we will help you. You can also view PCPs on our website at **www.MolinaHealthcare.com**. We can also send you a list of Contracted Providers in your area that includes:

- Name
- Address
- Specialty
- If the PCP will take new patients
- Language(s) spoken by the PCP

If you want to know about a PCP's medical training, board certification, etc., call Member Services at (800) 869-7165.

How do I change a PCP?

You can change a PCP by calling Member Services. Most changes will take place the first day of the next month.

Can I see any PCP who has a contract with Molina Healthcare or use any facility?

Your care must be directed by your assigned PCP who has a contract with Molina Healthcare for Basic Health. Except in an emergency, your PCP will Refer you if you need care from a Specialist, hospital or other healthcare provider. Your PCP must approve most of your specialty care except emergencies, mental health and women's healthcare. PCPs can Refer you to any provider or facility that has a contract with Molina Healthcare if the care is Medically Necessary.

Specialty Care

How do I get care from a Specialist?

If you think you need specialty care, contact your PCP. Your PCP must Refer you for most of your specialty care except emergencies, mental health and women's healthcare. If your PCP thinks you need specialty care your PCP will Refer you to a Specialist who has a contract with Molina Healthcare for Basic Health.

Prior Approval

In some cases, your PCP or the Specialist you are seeing will need to call Molina Healthcare and request Prior Approval of specialty care or services. This request for Prior Approval must be done before treatments or tests take place. Here is a list of some tests and treatments that require Prior Approval by Molina Healthcare:

- Cancer care from oncology providers
- Most medical supplies and equipment
- Services like MRI, CT or PET scans
- Visits to any provider who does not have a contract with Molina Healthcare
- Chiropractic (self-Refer or may be referred by PCP)
- Physical and Occupational Therapy
- Hospital care and most surgeries
- Drugs not listed on the Drug Formulary
    - Some in-the-office services such as special drug injections
    - Allergy shots
    - Cancer drug treatment
    - Depo-Lupron
    - Depo-Provera
    - Hormone therapy
    - Immunotherapy

We give all PCPs frequent updated lists of what needs Prior Approval. If you are not sure what needs to be approved, call Member Services at (800) 869-7165 or call your PCP. If a request for specialty care is denied by Molina Healthcare, we will send you a letter within three days of the Denial. You or your PCP can Appeal our decision (see "Grievance and Appeals"- page 18).

If you want to know about a Specialist's medical training, board certification, etc., call Member Services at (800) 869-7165.

If you need to see a Specialist for a non-urgent visit, it may take several weeks to get an appointment. If your PCP will not Refer you, call Member Services at (800) 869-7165.

How can I find out which Specialists have contracts with Molina Healthcare?

Call Member Services at (800) 869-7165 and we will help you. You can also view Specialists on our website at **www.MolinaHealthcare.com**. We can also send a list of Specialists that includes:

- Name
- Address
- Specialty
- Language(s) spoken by the Specialist

How do I get women's healthcare?

You can go to any women's healthcare provider who has a contract with Molina Healthcare without a Referral from your PCP. Women's healthcare providers are listed on our website at **www.MolinaHealthcare.com** or you can call Member Services at (800) 869-7165.

If you have a mastectomy, your Benefits will include:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce an even appearance
- Prostheses (special bra fillers or breast implants to restore breast shape)
- Treatment for physical complications from all stages of mastectomy, including lymphedema

Maternity Benefits program

If you think you might be pregnant, please see your women's healthcare provider right away. Getting good care early in pregnancy is very important for you and your baby.

Basic Health covers maternity care for only the first 30 days after diagnosis of pregnancy. To receive prenatal and maternity care after the first 30 days, you must call Basic Health at (800) 660-9840 and apply for the Maternity Benefits Program (see "Benefits Summary" - page 13).

If you are an HCTC program Member, you do not need to apply for the Maternity Benefits program. Your maternity care will be covered. Please call Basic Health to let them know you are pregnant.

Please notify Molina Healthcare and Basic Health about your new baby right away. Molina Healthcare has some special programs for you and your baby (see "Disease Management and Health Education Programs - page 28).

How do I get mental healthcare?

If you need mental healthcare, you can ask your PCP to Refer you to a mental health provider who has a contract with Molina Healthcare. You can see a counselor without a Referral from your PCP, but the counselor must have a contract with Molina Healthcare for Basic Health. To find out if your counselor is contracted with Molina Healthcare, call Member Services at (800) 869-7165 or go to our website at **www.MolinaHealthcare.com** (see "Benefits Summary" - page 14).

How do I get lab work done?

When you need lab work (like blood work) done, your provider will send the specimens to a lab to be tested. Sometimes you need to go directly to the lab for testing. Molina Healthcare has a preferred lab called Quest Diagnostics. To learn more about Quest Diagnostics call 866-MY-QUEST (697-8378) or go to their website at www.questdiagnostics.com.

Emergency Care and Urgent Care

How do I get Emergency Care and Urgent Care?

Emergency Care is for a sudden or severe health problem that needs care right away. It can also be care that is needed because you believe your life or health is in danger. Urgent Care is treatment for care needed right away, but your life or health is not in danger. Molina Healthcare covers you for Emergency Care and Urgent Care.

If you need Emergency Care call 911 or go to the nearest hospital. You do not need Prior Approval for Emergency Care or Urgent Care. If you are not sure if something is an emergency, you can call your PCP or

our 24-hour Nurse Advice Line at (888) 275-8750 for healthcare advice. If you cannot get an appointment with your PCP within 24 hours, go to an urgent care center.

Note: If you need to go to an emergency room or urgent care center, ask them to send records to your PCP. You should call your PCP soon after your emergency visit to coordinate care and get any Medically Necessary treatment.

What if I need care while away from home?

If you are outside of Molina Healthcare's Service Area for Basic Health, Molina Healthcare covers you for Emergency Care and Urgent Care only (see "How do I get Emergency Care and Urgent Care?" - page 8). Post emergency follow-up care and Routine Care are not covered outside of Molina Healthcare's Service Area (See "Definitions" - page 33).

Routine Care is pre-planned care such as a regular provider visit or pre-planned surgery. Routine Care must be from your PCP or other provider who has a contract with Molina Healthcare for Basic Health. Routine Care is not covered outside your Service Area. If you need Routine Care while out of the area, call your PCP or our 24-hour Nurse Advice Line at (888) 275-8750 for healthcare advice.

What if I need to go to the hospital?

Emergencies

- If you think you have an emergency call 911 or go to the nearest hospital or urgent care center
- If you are in the hospital because of an emergency, you or your representative must contact Molina Healthcare and your PCP by the next working day or as soon as possible

Planned Hospital Visits

- Planned non-emergent hospital visits must be approved by Molina Healthcare in advance. Your Provider and the hospital must call Molina Healthcare to arrange for your visit.
- You may have to pay the hospital if approval is not given by Molina Healthcare before you are admitted
- If you need a list of hospitals that have contracts with Molina Healthcare for Basic Health, call Member Services at (800) 869-7165 or visit our website at **www.MolinaHeathcare.com**.

How do I get care after hours?

If you need care after your PCP's office is closed:

- For emergencies, call 911 or go to the nearest hospital or urgent care center
- Call your PCP office to reach the provider on call
- Call our 24-hour Nurse Advice Line at (888) 275-8750 to get answers to your health questions at any time. The nurse will tell you if you need to go to the hospital. Sometimes a phone call can prevent a trip to the hospital.

What if I am in an accident?

If you are hurt in an accident, go to the nearest hospital or see your PCP.

Even if your care is covered by other insurance, contact Molina Healthcare as soon as possible so we can help manage your care. If there is other coverage, Molina Healthcare has the right to be repaid for any medical care paid by Molina Healthcare.

What if I am injured at work?

If you are hurt while on the job, you must tell your employer and file a report. Molina Healthcare expects you to use your Workers Compensation Benefits first.
Note: If you need to go to an emergency room or urgent care center, ask them to send records to your PCP.

How long will I have to wait to get an appointment?

Molina Healthcare wants you to have timely access to care. Our appointment standards are below.

Type of Care	Appointment Wait Time
Preventive Care (non-urgent)	Within 30 calendar days of request
Routine (non-urgent) - Primary Care	Within 10 calendar days of request
Urgent Care	Within 48 hours
Emergency Care	Available 24 hours/7 days
After-Hours Care	Available 24 hours/7 days
Office Waiting Time	Should not exceed 30 minutes

Call Member Services at (800) 869-7165 if you have any questions.

Cost Sharing Definitions

Co-pay

A co-pay is a set dollar amount you pay when receiving specific services or treatments. Co-pays do not apply to your deductible, coinsurance or out-of-pocket maximum. You will be responsible for the following co-pays:

- Office visit & Urgent Care - $15
- Prescription drugs:
    - Tier 1: $10 (or cost of drug, whichever is less)
    - Tier 2: 50% of the drug cost
- Emergency room visit - $100

See "American Indian/Alaska Native Members" – (page 11) for exceptions.

Deductible

A deductible is the amount you pay before Molina Healthcare starts to pay for some Covered Services. You will be responsible for paying the first $250 of some covered medical costs before Molina Healthcare pays the 80% coinsurance.

The $250 deductible has to be met for each family member enrolled in Basic Health. Your deductible does not

apply towards your out-of-pocket maximum.

If you change plans at any time during the year, the amount you have paid toward your deductible for covered family members will start over with your new health plan.

See "American Indian/Alaska Native Members" – (bottom of page) for exceptions.

Coinsurance

Coinsurance is the percentage you pay when Molina Healthcare pays less than 100% for Covered Services. Coinsurance does not apply until you have paid your annual deductible. You will be responsible for paying 20% of the cost for some services that have a coinsurance. Molina Healthcare pays the remaining 80%.

See "American Indian/Alaska Native Members" – (bottom of page) for exceptions.

Out-of-Pocket Maximum

Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you reach the out-of-pocket maximum, you are not responsible for any more coinsurance costs for Covered Services received during the year. Molina Healthcare will pay 100% of all coinsurance costs.

If you change plans any time during the year, the amount you have paid toward your out-of-pocket maximum for covered family members will start over with your new health plan.

See "American Indian/Alaska Native Members" – (bottom of page) for exceptions.

Explanation of Benefits (EOB)

Each time you receive medical services, you are sent a detailed statement from Molina Healthcare that explains which procedures and services were given, how much they cost, how much Molina Healthcare pays, and how much you pay. Your Explanation of Benefits also tracks your deductible and out-of-pocket maximum for each family member. If there are services on an EOB you do not believe you received, please call Member Services at (800) 869-7165 (see "Fraud, Waste and Abuse - page 20).

See "American Indian/Alaska Native Members" - (bottom of page) for exceptions

American Indian/Alaska Native (AI/AN) Members

Basic Health Members identified by Washington State Health Care Authority as American Indian/Alaska Native and enrolled through a Basic Health contracted Tribal Sponsor, do not have cost share. These Members do not have to pay:

- Co-pays
- Deductible
- Coinsurance

Since cost share does not apply, American Indian/Alaska Native members will not receive an Explanation of Benefits.

Benefits

What Is Covered Under The Plan?

To be covered, you must be a Member of Molina Healthcare and your care must be Medically Necessary.

Medically Necessary care is testing, treatment, or supplies that meet the definition given in the State's Basic Health Member Handbook. In general, this means the care is known as the safest and most cost effective test or treatment for the medical condition you have.

Benefits Summary

Pharmacy

AI/AN Members do not pay co-pays, deductibles or coinsurance (see "American Indian/Alaska Native (AI/AN) Members" - page 11).

Tier 1 - $10 Co-pay (or cost of drug, whichever is less)	Tier 2 - 50% Co-pay
• Generic drugs contained in the Molina Healthcare Drug Formulary • All oral contraceptives in the Molina Healthcare Drug Formulary • Diabetic supplies, including syringes and needles, diabetic test strips, lancets and insulin • Inhaled short-acting beta-agonists • Inhaled steroids • Inhaled anti-cholinergic bronchodilators • Beta-blockers for severe heart failure • Anti-platelet clotting inhibitors for patients after intra-arterial stent placement	• Brand-name drugs in the Molina Healthcare Drug Formulary

Benefits and services NOT subject to the deductible and coinsurance

The $250 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year DO NOT apply to the following Benefits and services. AI/AN Members do not pay co-pays, deductibles or coinsurance (see "American Indian/Alaska Native (AI/AN) Members" - page 11).

Benefit/Service	Member's Payment Responsibility	Notes
Preventive care	No co-pay	Includes routine physicals, immunizations, PAP tests, Mammograms, and other screening and testing when provided as part of the preventive care visit (see "Preventive Care Guidelines" - pages 29-30).
Office visits	$15 co-pay	Co-pay is for office visits only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. (Exception: Office visits in hospital settings, see "Coinsurance" - page 11). Co-pays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy	Tier 1 – $10 co-pay (or cost of drug, whichever is less) Tier 2 – 50% of the drug cost	30-day supply Tier 1 includes generic drugs in the Molina Healthcare Drug Formulary. Tier 2 includes brand-name drugs in health plan's preferred Drug Formulary.
Emergency room visit	$100 co-pay	If admitted no co-pay; hospital coinsurance and deductible would apply.
Out-of-area Emergency Care	$100 co-pay	If admitted no co-pay; hospital coinsurance and deductible would apply.
Urgent Care	$15 co-pay	Co-pay is for office visit only when provided in an Urgent Care setting. Deductible and coinsurance apply to all other services.
Skilled nursing, hospice and home healthcare	No co-pay	Covered as an alternative to hospital care at Molina Healthcare's discretion.
Maternity care	No co-pay	If the Member is eligible for the Maternity Benefits Program, maternity services are only covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through Washington Medicaid (see "Maternity Benefits" - page 8).

Oxygen	No co-pay	Includes equipment and supplies. Not subject to co-pays, coinsurance or deductible. Requires health plan authorization.

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the 80% coinsurance for the following Benefits, you must pay your $250 annual deductible. Once you meet your deductible, all your coinsurance payments will be applied toward your $1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for 100% of covered Benefits and services with a coinsurance. Members are only responsible for co-pays for Benefits and services as shown on page 13. If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan. AI/AN Members do not pay co-pays, deductibles or coinsurance (see "American Indian/Alaska Native (AI/AN) Members" - page 11).

Benefit/ service	Member's payment responsibility	Notes
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. If the Member is eligible for the Maternity Benefits program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through Washington Medicaid (see "Maternity Benefits" - page 8) See "Other professional services" below.
Hospital, outpatient	20% coinsurance; deductible applies	
Other professional services	20% coinsurance; deductible applies	Includes services received as an inpatient, including, but not limited to, surgeries, anesthesia, chemotherapy, echocardiography, radiation and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance	Facility charges may include but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. Outpatient visits are subject to $15 copay (see "Office" visits - page 13).
Laboratory	No co-pay or coinsurance for outpatient services 20% coinsurance for inpatient hospital-based laboratory services	Deductible applies to services with coinsurance.

Radiology	20% coinsurance, except for outpatient x-ray and ultrasound	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/ physical therapy/ occupational therapy	20% coinsurance; deductible applies	Up to a combined maximum of 12 visits per year. Of those, no more than six can be for chiropractic care. Visits qualify only when used as post-operative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply to inpatient $300 maximum facility charge per admittance	Inpatient visits limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 co-pay (see "Office visits" - page 13).
Organ transplants	Deductible, coinsurance and co-pays apply by specific service	Transplants that are not Pre-Authorized or are not performed in a Molina Healthcare-designated medical facility are not covered. No Benefits are provided for charges related to locating a donor, such as tissue typing of family members.

Exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of "Medically Necessary" for the diagnosis, treatment, or prevention of injury or illness or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions
2. Services not provided, ordered or authorized by Molina Healthcare or its Contracted Providers, except in an emergency
3. Services received before the Member's effective date of coverage
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied healthcare professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self-administered
5. Hospital charges for personal comfort items or a private room unless authorized or services such as telephones, televisions and guest trays
6. Emergency facility services for non-emergency conditions
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records
8. Sleep studies, except the initial sleep study authorized by the contracted health plan. Only one sleep study per Member per calendar year is covered
9. Transportation except as specified under "Organ transplants" and "Emergency Care."
10. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment or required because of where you reside are not covered
11. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens

following cataract surgery) and implants as defined in the “Plastic and reconstructive services” benefit

12. Sex change operations
13. Investigation of or treatment for infertility or impotence
14. Reversal of sterilization
15. Artificial insemination
16. In-vitro fertilization
17. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under “Preventive care” - page 13.
18. Hearing aids
19. Orthopedic shoes and routine foot care
20. Speech and recreation therapy
21. Medical equipment and supplies not specifically listed in this “Schedule of Benefits” except while the Member is hospitalized (including, but not limited to, hospital beds, wheelchairs, and walk aids)
22. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair due to accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the Member is eligible for Covered Services at the time that services are provided
23. Medical services, drugs, supplies or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling or intestinal bypass)
24. Weight loss programs
25. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this “Benefits Summary” - page 12.
26. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the Member’s medical expenses without a determination of liability to the extent that payment would result in double recovery
27. Conditions resulting from acts of war (declared or not)
28. Direct complications arising from excluded services
29. Replacement of lost or stolen medications
30. Evaluation and treatment of learning disabilities, including dyslexia
31. Any service or supply not specifically listed as Covered Service unless Medically Necessary, prescribed by a contracting provider and Pre-Authorized in advance

Who can prescribe drugs for me?

In order for your drugs to be covered, they must be prescribed by a provider who has a contract with Molina Healthcare.

Can I use any pharmacy I choose?

Molina Healthcare has contracts with most pharmacies. You must get your drugs at one of these pharmacies. A list of these pharmacies is on our website at **www.MolinaHealthcare.com**. You can also call Member Services at (800) 869-7165 to find out which pharmacy is closest to you or if you have problems getting your drugs at the pharmacy.

Does Molina Healthcare cover all drugs prescribed by my PCP?

Molina Healthcare uses a list of approved drugs. This is called a Drug Formulary. The list is put together by a group of providers and pharmacists. Your PCP or provider should prescribe drugs to you from this list. This

list is on our website at **www.MolinaHealthcare.com**.

Certain drugs on the list will need Prior Approval from Molina Healthcare. Your PCP will need to send Molina Healthcare a request and get Prior Approval before these drugs will be covered.

If your provider or Specialist wants you to have a drug that is not on the list, your PCP can send us a request for approval. If the request is denied, you or your PCP can Appeal our decision (see "Grievances and Appeals" - page 18).

Call Member Services at (800) 869-7165 if you want:

- A copy of the drug list
- Information about the group of providers and pharmacists who created the list
- A copy of the policy on how Molina Healthcare decides what drugs are covered

How does Molina Healthcare review new technology?

Molina Healthcare reviews new equipment, drugs and procedures to decide if they should be covered. Some new equipment, drugs and procedures are still being tested to see if they really help. If they are still being tested they are called experimental or investigational. Experimental and investigational services are only covered when research shows they are more helpful than harmful. If you want to know more about this, call Member Services at (800) 869-7165.

If your provider requests a service for you and it is denied because it is experimental or investigational, you or your provider can Appeal Molina Healthcare's decision (see "Grievance and Appeals" - page 18).

You have the right to give your consent

You have the right to know about possible side effects and Benefits of your care. Be sure to ask your PCP about possible side effects of your care. You have the right to give or not give your consent before you get care.

Advance Directives

Advance directives put your health choices into writing. They may also name someone to speak for you if you are not able to speak for yourself. Washington State law has two kinds of advance directives:

1. Durable Power of Attorney for Health Care - This names another person to make medical decisions for you, if you are not able to make them for yourself.
2. A Directive to Physicians (Living Will) - A statement that you want to die naturally and do not wish to have treatments that will prolong your life.

Call Member Services at (800) 869-7165 and we can send you more information on advance directives.

Does Molina Healthcare have a quality improvement program?

Yes. If you want a copy of Molina Healthcare's Quality Improvement Program description or progress report, call Member Services at (800) 869-7165.

How does Molina Healthcare pay providers?

We make decisions about your covered care based on what you need. Molina Healthcare does not reward

providers, employees or other people to deny or limit your care. Molina Healthcare does not encourage over-use or under-use of tests or treatments.

If you would like to know more about how Molina Healthcare pays providers, call Member Services at (800) 869-7165.

What do I have to pay for?

You have to pay a co-pay for some Covered Services and coinsurance and deductible for others. See the Cost Sharing Definitions and Benefit Summary pages 10-12 for details on cost sharing and Covered Services. You may also have to pay a charge if you miss your appointment.

You will be responsible for all billed charges if a service is not covered by Basic Health or you receive care from a provider who does not have a contract with Molina Healthcare (except Emergency Care and Molina Healthcare Pre-Authorized care).

If you have questions, call Member Services at (800) 869-7165.

Grievance and Appeals

GRIEVANCE

Grievances are Complaints. If you are unhappy with the service from Molina Healthcare or providers who contract with Molina Healthcare, you have the right to file a Grievance. You may write, email, call or fax your Grievance to:

Molina Healthcare of Washington
Attn: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Phone: (800) 869-7165
Fax: (425) 424-1172
Email: wamemberservices@molinahealthcare.com

We will let you know we got your Grievance either on the phone or in writing within two business days. We will try to take care of your Grievance right away. If we cannot, we will contact you within 30 calendar days of getting your Grievance. Molina Healthcare will keep your Grievance private, except as needed to respond to you.

APPEAL PROCESS

An Appeal is a request for Molina Healthcare to review a Denial or service. You have the right to Appeal if your service was not approved, we changed an approved service or you have to wait too long to make an appointment. Below (in order) are the steps to the Appeal process:
1. Appeal
2. HCA Hearing
3. Independent Review
4. HCA/DSHS Board of Appeals Hearing

Appeal:

Members may choose someone, including an attorney or provider, to serve as their personal representative to act on their behalf for the appeal. Molina Healthcare must receive a written consent form that allows this person to represent you before the person can act on your behalf for your appeal. Molina Healthcare does not

cover any fee payments to your representatives. Any such fees would be your payment responsibility.

To file an Appeal:

After the date of Molina Healthcare's notice of Action you or your personal representative have 90 calendar days to file an Appeal if you disagree with the decision.

We can help you with an Appeal. Any data you give us for an Appeal will be kept private. If you want to Appeal, write, fax, email or call Member Appeals at:

Molina Healthcare of Washington
Attn: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Phone: (800) 869-7175, Ext. 141002
Fax: (425) 424-1172
Email: wamemberservices@molinahealthcare.com

If you Appeal, a different doctor, not involved in the first decision, will review your case. We will let you know we got your Appeal in writing within five working days. We will respond to you in writing within 14 calendar days, unless we notify you in writing we need more time to make a decision. This process will not take longer than 30 calendar days. If waiting for a decision could put your health at risk, ask for an expedited (quick) review. We will make a decision and respond to you within 72 hours.

At any time during the Appeal process, you or your personal representative may submit written comments, papers or other data about the Appeal in person, as well as in writing.

Please call us if you would like copies of:
- Any medical data, including the benefit or guideline, used to make the Appeal decision
- The documents used in the Appeal decision

HCA Hearing:

You must use and complete Molina Healthcare's Grievance and Appeal process before you can have a HCA hearing. Then, if you do not agree with an Appeal decision, you have the right to a hearing. You may ask for a HCA hearing in writing.

To ask for a HCA Hearing:
- Contact the Office of Administrative Hearings (www.oah.wa.gov) at (800) 558-4857 or write to them at: PO Box 42488, Olympia, Washington 98504-2488
- Tell the Office of Administrative Hearings the reason for the hearing
- You may consult with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at (888) 201-1014.
- Your provider may not ask for a HCA hearing for you. You must ask for a hearing within 90 calendar days of the date on the letter deciding your Appeal. When you ask for a HCA hearing, you will need to tell them what service was denied, when it was denied, and the reason it was denied. You can have someone speak for you at the hearing.

Independent Review:

You have the right to an independent review. You must ask for this within 180 calendar days of the last decision. Call Member Services at (800) 869-7165 and we will help you. If you ask for an independent review, your case will be sent to an Independent Review Organization (IRO). This will be done within three working days of

getting your request. The IRO usually makes a decision within 15 calendar days. Molina Healthcare will let you know the outcome. If waiting for a decision could put your health at risk, ask for an expedited (quick) review. The IRO will make a decision within 72 hours. Molina Healthcare will let you know the outcome. There is no cost to you for an independent review. If the IRO changes our decision, your claim will be paid or approval updated, within 15 working days. If an Appeal for a service is changed, call your provider to schedule a visit.

HCA/DSHS Board of Appeals Hearing:

If you do not agree with the IRO decision, you have the right to a HCA/DSHS Board of Appeals hearing. You must ask for this within 21 calendar days after the IRO decision is mailed. If you want this hearing, please contact the address below and ask how to do this:

HCA/DSHS Board of Appeals
PO Box 45803
Olympia, WA 98504-5803

Phone: (360) 664-6100
Toll-free: (877) 351-0002

Fax: (360) 664-6187

Did we change, reduce or end your service? If so, you have the right to Appeal. If you ask for:

- An Appeal
- A HCA hearing
- An IRO
- A HCA/DSHS Board of Appeals hearing

You may be able to keep getting the service until a final decision is made. You have ten calendar days after the date of the decision to request this. Molina Healthcare will review your request to keep getting the service. However, if the Denial is not changed, you may need to pay for the service you received.

Fraud, Waste and Abuse

What is healthcare fraud, waste and abuse?

Healthcare fraud and abuse occurs in every area of healthcare. Healthcare fraud is the intentional falsification of a fact on a healthcare claim in order to receive payment or services not owed to them. Healthcare waste and abuse describes practices that directly or indirectly result in unnecessary costs to a healthcare program and its Members.

Who commits healthcare fraud, waste or abuse?

Providers can commit healthcare fraud, waste or abuse by:

- Billing incorrectly
- Billing for services never rendered, inappropriate/unnecessary services or "free services"
- Making false claims about qualifications, licensure and/or education
- Falsifying records to suggest ongoing medical services
- Forging a physician's signature on plans of care
- Altering information on care plans, prescriptions and/or other medical documentation
- Billing for multiple family members when only one family member received service(s) and/or supplies
- Changing or incorrectly coding a claim to receive maximum payment
- Falsifying the diagnosis or procedure to maximize payments
- Changing dates of service for double billing

Patients can commit healthcare fraud, waste and abuse by:

- Sharing health insurance ID cards
- Claiming non-covered dependents
- Participating in doctor shopping ("Doctor Shopping" is a term commonly used to refer to a patient who may or may not have a real physical illness, but goes from doctor to doctor with the objective of improperly obtaining multiple prescriptions for narcotic painkillers)
- Consenting with doctors to submit claims for services not received or not necessary
- Fabricating claims
- Altering submitted medical documentation of any type
- Using a stolen health insurance ID card to obtain healthcare services
- Using a deceased Member's health insurance ID card to obtain healthcare services
- Ineligible persons using an eligible person's health insurance ID card to obtain medical services or Benefits

How can I help stop healthcare fraud?

Healthcare fraud takes money from healthcare programs and leaves less money for real medical care. Here are some ways you can help stop fraud:

- Do not give your Molina Healthcare ID card or ID number to anyone other than a healthcare provider, a clinic or hospital and only when receiving care
- Do not let anyone borrow your Molina Healthcare ID card
- Do not sign a blank insurance form
- Be careful about giving out your Social Security number
- Be careful of anyone who offers you "free" tests and services in exchange for your Molina Healthcare card number

You can report fraud by:

- Phone: (800) 869-7165 (Member Services)
- Fax: (800) 282-9929
- Email: mhwcompliance@molinahealthcare.com

You can report fraud, without giving us your name, by:

- Phone (866) 702-0404 (Confidential Compliance Voicemail Box)
- Fax: (800) 282-9929
- Email: mhwcompliance@molinahealthcare.com
- Mail:
  Attn: Compliance Director (CONFIDENTIAL)
  Molina Healthcare of Washington
  PO Box 4004
  Bothell, WA 98041-4004

If you think fraud has taken place, contact Basic Health at:

- (800) 660-9840 to report Basic Health client fraud
- (800) 562-6906 or hottips@hca.wa.gov to report provider fraud

For those who do not have access to computers in your home, Internet access is available at your local public library.

Protecting Your Privacy

Molina Healthcare takes confidentiality very seriously. We want to let you know how your health information is shared or used.

Your Protected Health Information (PHI)

PHI means health information that is used or shared by Molina Healthcare. PHI includes your name, Member ID number or other things that can be used to identify you.

Why does Molina Healthcare use or share our Members' PHI?

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

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

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

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word or PHI in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI
- Only Molina Healthcare staff with a need to know PHI may use PHI
- Molina Healthcare staff is trained on how to protect and secure PHI
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

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

- Call or write Molina Healthcare to file a Complaint
- File a Complaint with the U.S. Department of Health and Human Services

The above is only a summary. The following Notice of Privacy Practices has more information about how

we use and share our Members' PHI. It is also on our website at **www.MolinaHealthcare.com**. You also may get a copy of our Notice of Privacy Practices by calling Member Services at (800) 869-7165.

NOTICE OF PRIVACY PRACTICES

MOLINA HEALTHCARE OF WASHINGTON, INC.

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

Molina Healthcare of Washington, Inc. ("Molina Healthcare" or "we") uses and shares Protected Health Information about you to provide your health Benefits. We use and share your information to carry out treatment, payment and healthcare operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is January 1, 2008.

PHI stands for Protected Health Information. PHI means health information such as medical records that include your name, Member ID number or other identifiers and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share your PHI?

We use or share your PHI to provide you with healthcare Benefits. Your PHI is used or shared for treatment, payment and healthcare operations.

For Treatment
Molina Healthcare may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes Referrals between your PCP and other healthcare providers. For example, Molina Healthcare may share information about your health condition with a Specialist. This helps the Specialist talk about your treatment with your PCP.

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

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

Healthcare operations involve many daily business needs. They include, but are not limited, to the following:

- Improving quality
- Actions in health programs to help Members with certain conditions (such as asthma)
- Conducting or arranging for medical review
- Legal services, including fraud and abuse programs
- Actions to help us obey laws

- Addressing Member needs, including solving Complaints and Grievances.

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

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

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care and
- You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected

The law allows or requires Molina Healthcare to use and share your PHI for the following other purposes:

Required by law

Molina Healthcare will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (DHHS).

Public Health

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

Healthcare Oversight

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

Research

Your PHI may be used or shared for research in certain cases, when approved by a privacy or institutional review board.

Legal or Administrative Proceedings

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

Law Enforcement

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

Health and Safety

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

Government Functions

Your PHI may be shared with the government for special functions, such as national security activities.

Victims of Abuse, Neglect or Domestic Violence

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

Workers Compensation

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

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

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

Molina Healthcare needs your written approval to use or share your PHI for a purpose other than those listed in this notice. You may cancel a written approval that you have given to Molina Healthcare. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)
You may ask Molina Healthcare not to share your PHI to carry out treatment, payment or healthcare operations. You may also ask us to not share your PHI with family, friends or other persons you name who are involved in your healthcare. However, Molina Healthcare is not required to agree to your request. You will need to fill out a form to make your request.

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

Review and Copy Your PHI
You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare Member. You will need to fill out a form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request.

Important Note: We do not have complete copies of your medical records. Please contact your PCP to get a copy of your medical chart.

Amend Your PHI
You may ask that we amend (change) your PHI. This involves only those records kept by Molina Healthcare about you as a Member. You will need to fill out a form to make your request. You may file a letter disagreeing with us if we deny the request.

Receive an Accounting of PHI Disclosures (Sharing of your PHI)
You may ask that Molina Healthcare give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- For treatment, payment or healthcare operations
- To persons about their own PHI
- Sharing done with your authorization
- Incident to a use or disclosure otherwise permitted or required under applicable law;
- As part of a limited data set for research or public health activities;
- PHI released in the interest of national security or for intelligence purposes;

- To correctional institutions having custody of an inmate; or
- Shared prior to April 14, 2003

You must fill out a form to request a list of PHI disclosures. We may charge a reasonable fee if you ask for this list more than once in a 12-month period.

You may make any of the requests listed above. Please call the Manager of Member Services at (800) 869-7175.

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

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

You may send us a Complaint at:

Molina Healthcare of Washington
Manager of Member Services
PO Box 4004
Bothell, WA 98041-4004
Phone: (800) 869-7165

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

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – Mail Stop RX-11
Seattle, WA 98121-1831
Phone (206) 615-2290
TTY (206) 615-2296

What are the duties of Molina Healthcare?

Molina Healthcare is required to:

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

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

Contact Information

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

Molina Healthcare of Washington
Manager of Member Services
21540 30th Dr. SE Ste. 400
Bothell, WA 98021
Phone: (800) 869-7165

You can also write us at:

Molina Healthcare of Washington
Attn: Member Services
PO Box 4004
Bothell, WA 98041-4004

Your Rights and Responsibilities

Note: This is a partial list of Member rights and responsibilities. For a full list please go to www.basichealth.hca.wa.gov.

You have the right to:

- Get the facts about Molina Healthcare, our services and providers who contract with us to provide services
- Have privacy and be treated with respect and dignity
- Help make decisions about your healthcare. You may refuse treatment.
- Go get a second opinion from another Molina Healthcare Contracted Provider
- Ask for and receive a copy of your medical records or ask for Molina Healthcare to amend or correct them
- Openly talk about all your treatment options in a way you understand. It does not matter what the cost or Benefit coverage.
- Voice any Complaints or Appeals about Molina Healthcare or the care you were given
- Use your Member rights without fear of negative results
- Receive the Members' Rights and Responsibilities at least yearly
- Suggest changes to this policy

You have the responsibility to:

- Give, if you can, all facts that Molina Healthcare and the providers need to care for you
- Know your health problems and take part in making agreed upon treatment goals as much as possible
- Follow the plan and instructions for care you agree to with your provider
- Treat your providers with respect
- Keep appointments and be on time. If you are going to be late or cannot keep the appointment, call your provider.

Services

Disease Management & Health Education Programs

Call Member Services at (800) 869-7165 for more on these programs.

Prenatal program with car seat or booster seat

To be in this program, you must see your provider in the first three months of your pregnancy or within 42 calendar days of joining Molina Healthcare and you must be a Molina Healthcare Member at the time you deliver your baby. When you finish our program and fill out a quiz, we will send you a gift card for a car seat or booster seat. Our car seat safety program will help you learn how to safely use a car seat or booster seat for your baby.

After delivery program

It is important to maintain your health after giving birth to your baby. Molina Healthcare will send you a reminder in the mail to see your PCP. If you see your Molina Healthcare PCP for after-delivery care, you will get a gift card.

Well-child program

An important part of a healthy child's life is to have well-child exams. These exams start at birth and should continue through adolescence. A well-child exam has four parts:

- Health history
- Physical exam
- Anticipatory guidance (planning for future events in your child's life)
- Immunizations (as needed at the time)

Molina Healthcare's Well-child program is for children 1 to 13 years of age. Every year, your child will be sent a well-child reminder. Bring the reminder with you to the next well-child visit. Your provider will fax the reminder to Molina Healthcare and your child will be sent a gift. **It is important for children ages 12-13 years to go to their yearly well-child visit and receive their fourth Tdap shot.**

Immunization card

When your baby is nine months old you will be mailed a chart showing the shots your child should have received by nine months. The chart will also show you what shots your child still needs to stay healthy. Along with the chart, you will get a Lifetime Immunization card to help you keep track of your child's shots.

breathe with ease℠ program

This program is for our Members ages 2-56 with asthma.

Healthy Living with Diabetes℠ program

This program is for our Members ages 2-75 with diabetes.

Heart Healthy Living℠ Cardiovascular program

This program is for our Members ages 18 and older who have one or more of the conditions below:

- Hypertension
- Coronary Artery Disease
- Congestive Heart Failure

Living with COPD program

This program is for our Members ages 35 and older who have chronic obstructive pulmonary disease (COPD) such as chronic bronchitis and chronic emphysema.

You can get more details about these programs or tell us you do not want to be in any of the programs by calling our Health and Wellness department at (866) 891-2320. You can also go to our website at **www.MolinaHealthcare.com** for more disease management and health education tips.

Stop Smoking program (Free and Clear®)

Smoking is a risk factor for your health and those around you. We have a program that can make it easier to quit. This stop smoking program is a covered benefit for Molina Healthcare Members over age 18 or pregnant Members of any age. You can be in the stop smoking program three times during your lifetime. Program members will get:

- Free one-on-one counseling by phone
- Information sent to your home
- A toll-free quit line to call at any time for help between scheduled calls
- Nicotine replacement therapy or anti-smoking medicine therapy

If you would like to enroll or if you have questions, please call the Washington State Quit Line at:

- (800) 784-8669 English
- (877) 266-3863 Spanish
- (877) 777-6534 TTY

For more information on our stop smoking program contact Member Services at (800) 869-7165.

Suggested Preventive Care Guidelines for Children

An important part of a healthy child's life is to have well-child exams. These exams start at birth and should continue through the child's adolescence. A well-child exam has four parts:

- Health history
- Physical exam
- Anticipatory guidance (planning for future events in your child's life)
- Immunizations (as needed at the time of well-child visit)

Being up-to-date on shots is a very important way to make sure your child is growing, learning and staying healthy. Molina Healthcare sends your child a birthday well-child reminder every year. Bring the reminder with you to the next well-child visit. Your provider will fax the reminder to Molina Healthcare and your child will be sent a gift.

Follow the shot charts below to make sure your child stays healthy. Call your provider if you have any questions.

Immunizations for Children 0 – 6 years – United States 2010 — Recommended age / Certain high risk groups

Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19 – 23 months	2 – 3 years	4 – 6 years
Hepatitis B	HepB	HepB			HepB						
Rotavirus			RV	RV	RV						
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				DTaP
Haemophilus influenza type b			Hib	Hib	Hib	Hib					
Pneumococcal			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza					Influenza (Yearly)						
Measles, Mumps, Rubella						MMR					MMR
Varicella						Varicella					Varicella
Hepatitis A						HepA (2 doses)				HepA Series	
Meningococcal											MCV

Immunizations for Children 7 – 18 years – United States 2010 — Recommended age / Certain high risk groups

Vaccine	7 – 10 years	11 – 12 years	13 – 18 years
Diphtheria, Tetanus, Pertussis		Tdap	*Tdap catch-up*
Human Papilloma Virus		HPV (3 doses)	*HPV Series catch-up*
Meningococcal	MCV4	MCV	*MCV catch-up*
Pneumococcal		PPSV	
Influenza		Influenza (Yearly)	
Hepatitis A		HepA Series	
Hepatitis B	*HepB Series catch-up*		
Inactivated Poliovirus	*IPV Series catch-up*		
Measles, Mumps, Rubella	*MMR Series catch-up*		
Varicella	*Varicella Series catch-up*		

CDC. Recommended childhood and adolescent immunization schedule---United States. MMWR 2007;55(51&52):Q1--Q4.

Suggested Preventive Care Guidelines for Adults

These guidelines are suggestions for preventive care. You and your provider may decide these services should be done more or less often.

Health Visit	19 to 39 Years	40 to 64 Years	65 and Over
Includes physical exam, preventive screening and counseling	Ages 19 – 21, annually Ages 22 – 39, every 1 – 3 years depending upon risk factors	Ages 40 – 49, every 1 – 3 years depending upon risk factors, Ages 50 – 64, annually	Annually
Cancer Screening			
Breast Cancer	Breast exam by provider and self-exam teaching. Mammogram for patients at high risk.	Breast exam by provider and self-exam teaching. Mammogram every 1 – 2 years.	Breast exam by provider and self-exam teaching. Annual mammogram through age 69. After age 70, per provider decision.
Cervical Cancer (Pap Test and Pelvic Exam	Every 1 – 3 years depending upon risk factors.	Every 1 – 3 years depending upon risk factors.	Every 1 – 3 years per provider decision.
Colorectal Cancer		Colonoscopy at age 50, then once every 10 years or annual fecal occult blood test plus sigmoidoscopy every 5 years.	At age 70, at age 80 per provider decision.
Testicular and Prostate Cancer	Testicular exam by provider and self-exam. Prostate cancer screening not routine.	Ages 40 to 49, prostate exam by provider for high risk patients. Age 50, prostate exam by provider.	Prostate exam by per provider decision.
Skin Cancer	Ages 20 – 39, every 3 years.	Age 40 and older, annually.	Annually and at provider decision.
Other Screenings			
Hypertension (blood pressure)	At every provider visit and at least once every 2 years.	At every provider visit and at least once every 2 years.	At every provider visit and at least once every 2 years.
Cholesterol	Screen every 5 years for total cholesterol, LDL, HDL, and triglycerides.	Screen every 5 years for total cholesterol, LDL, HDL, and triglycerides.	Screen every 5 years for total cholesterol, LDL, HDL, and triglycerides.
Diabetes (Type 2)	Screen if overweight and if risk factors are present.	Age 45, begin screening.	
Infectious Disease Screening			
Chlamydia and gonorrhea	Ages 16 – 25, sexually active, annually. Screen pregnant women at first prenatal visit and in the third trimester, if at risk.	Test all patients at high risk.	Test all patients at high risk.
Health Visit	**19 to 39 Years**	**40 to 64 Years**	**65 and Over**
Syphilis	Screen pregnant women at the first prenatal visit and in the third trimester, if at risk.		
HIV	Test all patients at high risk.	Test all patients at high risk.	Test all patients at high risk.
Tuberculosis (TB)	Skin testing of all patients at high risk.	Skin testing of all patients at high risk.	Skin testing of all patients at high risk.

Immunizations			
Tetanus, Diphtheria (Td/Tdap)	Adults who got their last dose of Td 10 or more years ago should get one dose of Tdap. Adults who have never been immunized should be given 3 doses. Booster every 10 years.	Every 10 years (give one dose of Tdap if pertussis booster was not given before).	Every 10 years (give one dose of Tdap if pertussis booster was not given before).
Varicella (Chicken Pox)	Adults, 2 doses, given one month apart, if not immunized and no history of chicken pox or shingles or if at high risk.	Adults, 2 doses, given one month apart, if not immunized and no history of chicken pox or shingles or if at high risk.	Adults, 2 doses, given one month apart, if not immunized and no history of chicken pox or shingles or if at high risk.
Influenza	Annually	Annually	Annually
Pneumococcal	If at high risk and not given before.	If at high risk and not given before.	Once after age 65 years, even if given before age 65.
Hepatitis A & B	If at high risk and not given before. Only once in a lifetime.	If at high risk and not given before. Only once in a lifetime.	If at high risk and not given before. Only once in a lifetime.

These guidelines were taken from the Massachusetts Health Quality Partners Adult Preventive Care Recommendations and are recommendations only. They do not explain Benefits, payments, or any other legal options. Molina Healthcare makes the decision of coverage and Benefits.

Definitions

Below are definitions of words that appear in this Member handbook and may help you to understand this booklet.

APPEAL – A request for Molina Healthcare to review our decision. An Appeal may be made by a Member, a Member representative or provider on behalf of a Member with written consent.

BENEFITS– The Medically Necessary services covered under your health plan.

COMPLAINT/GRIEVANCE – A written or oral statement when you are unhappy with your health plan services, provider or care. This statement can be made by a Member or Member representative.

CONTRACTED PROVIDER – Doctors, hospitals and other providers who have a contract with Molina Healthcare.

COVERED SERVICES - The Medically Necessary services covered under your health plan.

DENIAL /ACTION – A Denial or limited authorization of a requested service.

DRUG FORMULARY – A list of preferred drugs developed with pharmacists and providers to encourage greater efficiency in the dispensing of prescription drugs without giving up quality.

EMERGENCY CARE – Treatment for a sudden or severe health problem including severe pain that needs care right away. It can also be care that is needed because you think your life or health is in danger.

MEDICALLY NECESSARY - Medical care needed to prevent, diagnose or treat health problems. (See the State's Basic Health Member Handbook for full definition in Appendix A: Schedule of Benefits.)

MEMBER – A person eligible for Basic Health Covered Services who is enrolled in Molina Healthcare through the Washington State Health Care Authority.

MOLINA HEALTHCARE ID CARD – When you enroll, you receive one ID card from Molina Healthcare. Always carry the ID card with you and show it when you get medical or pharmacy services.

NON-CONTRACTED PROVIDER – Doctors, hospitals and other providers who do not have a contract with Molina Healthcare.

PROTECTED HEALTH INFORMATION (PHI) – Health information such as medical records that include your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

PRE-AUTHORIZATION/PRIOR APPROVAL – Molina Healthcare's approval ahead of time for some specialty or other Medically Necessary care. This includes some medications.

PRIMARY CARE PROVIDER (PCP) – Provides care for most common problems, health or disease screenings and Refers you to specialty care. A PCP may be a family/general provider, internist, pediatrician, or ARNP who has a contract with Molina Healthcare for Basic Health.

REFERRAL/REFER – A request from your PCP for you to get specialty care.

ROUTINE CARE – Any pre-planned care such as a regular provider visit.

SERVICE AREA – The counties that Molina Healthcare serves under the Basic Health contract with the Health Care Authority.

SPECIALIST – Any provider who practices a specialty (heart doctor, skin doctor) and who has a contract with Molina Healthcare to deliver Covered Services for Basic Health. This includes OB/GYNs.

URGENT CARE - Treatment for care needed right away, but your life or health is not in danger.

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