Your Member Handbook

Nebraska
Medicaid
Last updated 09/2023

MolinaHealthcare.com

MOLINA® HEALTHCARE | HERITAGE HEALTH

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-782-2018 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-782-2018 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-782-2018 (TTY: 711).
Chinese	注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-844-782-2018（TTY：711）。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-782-2018) (رقم هاتف الصم والبكم: 711).
Karen	ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤ ကညီကျိာ်အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆီဉ်ထွဲမၤစၢၤတၢ်မၤ, လၢတလာ်ဘူဉ်လာ်စ့ၤတဖဉ်, လၢနဂီၢ်နှဉ်လီၤ. ကိး 1-844-782-2018 (TTY 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-844-782-2018 (TTY: 711).
Cushite - Oromoo (Oromo)	HUBACHIISA: Afaan Ingilizii kan dubbattan yoo ta'e, tajaajilootni deggera afaanii, kaffaltii irraa bilisa haala ta'een isiniif dhiyaata. 1-844-782-2018 (TTY: 711) irratti bilbilaa.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-782-2018 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-782-2018 (TTY: 711) 번으로 전화해 주십시오.
Nepali	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-782-2018 (टिटिवाइ: 711) ।
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-782-2018 (телетайп: 711).
Laotian	**ໂປດຊາບ: ຖ້າອ່ຽ ທ່ຽນເວົ້ຽພຽສ ລຽອ, ກຽນບໍລິກຽນຊ່ວຍເຫຼືອດ້ຽນພຽສ, ໂດຍບໍ່ເສັຽຄ່ຽ, ແມ່ນມີພ້ອມໃຫ້ທ່ຽນ. ໂທຣ 1-844-782-2018 (TTY: 711).**
Kurdish	ئاگادارى: ئەگەر بە کوردى سۆرانى قسە دەکەیت، خزمەتگوزارى هاوکارى زمان، بەخۆڕایى بۆ تۆ بەردەستە. پەیوەندى بە 18447822018 (ژمارەى خۆڕایى 711) بکە.
Persian (Farsi)	توجه: اگر فارسی صحبت می کنید، خدمات کمک زبان به صورت رایگان ارائه می شود. با شماره 1-844-782-2018 (TTY: 711) تماس بگیرید.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-782-2018（TTY：711）まで、お電話にてご連絡ください

Contents

Welcome

Thank you for choosing Molina Healthcare of Nebraska (Molina)! Since we opened our doors in 1980, it has been our mission to provide quality health care to everyone. We are here for you. And today, as always, we do all we can to help you feel your best.

This handbook is your guide to the services we offer. It also gives you helpful tips about Molina. Please read it and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and at no charge to you. Contact Member Services at **(844) 782-2018 (TTY: 711)**. You can also find this handbook on the web at **MolinaHealthcare.com/NE**.

What is the Heritage Health program?

Heritage Health is a health care delivery program that combines Nebraska's current physical health, behavioral health, dental, and pharmacy programs into a single complete and coordinated system for Nebraska's Medicaid and Children's Health Insurance Program (CHIP) clients.

Molina is one of the managed care plans contracted with the Department of Health and Human Services (DHHS). Molina gives Medicaid members access to quality, cost-effective healthcare. To do this, we contract with doctors, dentists, specialists, hospitals, pharmacies, and other healthcare providers.

Getting started

Are you new to Molina? If so, follow these steps to start getting the most from your plan:

1. **Review your Welcome Kit:** Your Welcome Kit has important information about your new health plan. It includes a Quick Start Guide to help you start using your benefits and managing your plan.

   You should have gotten your Molina member ID card with your Welcome Kit. There's one card for each family member enrolled in Molina. Please keep it with you at all times. If you haven't gotten your member ID card, visit **MyMolina.com** or contact Member Services at **(844) 782-2018 (TTY: 711)**.

2. **Register for the My Molina® mobile app**: My Molina® is your personalized member portal on your smartphone. Download the app and log in with your member ID number. With the My Molina app, you can change your primary care provider (PCP), view your service history, request a new ID card, and more! You can connect from any smart device.

   For help on the go, download My Molina® at no cost from your smartphone's app store. Just search for **My Molina**.

3. **Talk about your health**: When we understand your health, we can identify how to give you the best possible care. We'll call you for a short survey about your health history. Please let us know if your contact information changes.

4. **Get to know your primary care provider (PCP)**: Your PCP is your main doctor. Please schedule an appointment within 60 days. That way, you can start a relationship with your PCP. They can get to know your health and how to best treat you. To choose or change your PCP, go to **MyMolina.com** or contact Member Services at **(844) 782-2018 (TTY: 711)**.

5. **Get to know your benefits**: With Molina, you get all your Medicaid benefits **plus** no-cost extras. We offer incentives for preventive care and screenings, transportation, health education, and more. Our teams are committed to your care.

Our job is to make sure you get the care and services you need. We communicate with members via phone, mail, email, and/or text. Contact Member Services at **(844) 782-2018 (TTY: 711)** for questions about our services.

This member handbook helps you understand how to get health care when you need it. It also explains your benefits, your rights, and your responsibilities as a Molina member. Please read this handbook carefully.

Molina does not deny services based on moral or religious objections. We work with other companies to provide services – for example – transportation. Services provided by any company working with Molina are held to our standards and will be seamless for you. If you experience any problems, please contact Member Services.

Translations and interpreter services

If you speak a different language or need something in Braille, large print, or audio, don't worry – we will interpret or translate any of our member documents into your preferred language (including sign language). Just contact us and tell us the language you need. We can even arrange to have a translator or sign language interpreter at your appointments. (The interpreter might be on the phone.) Just contact us toll-free at **(844) 782-2018 (TTY: 711)**. We're here Monday-Friday from 8 a.m.-6 p.m. CT. This service is available at no charge to you.

A translator can help you:

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

Important contact information

Member Services

Toll-free phone number: **(844) 782-2018 (TTY: 711)**

Fax: **(833) 558-0329**

Hours of operation: Monday-Friday from 8 a.m.-6 p.m. CT

Website: **MolinaHealthcare.com/NE**

Address: 14748 W Center Rd, Suite 104, Omaha, NE 68144

Contact Member Services for things like:

- Finding a doctor or other provider
- Getting a new member ID card
- Understanding covered and non-covered benefits
- Requesting a printed copy of the provider directory or member handbook
- Reporting possible fraud issues by a member or provider
- Changing your address and phone number
- Case management services

Nebraska Department of Health and Human Services (DHHS) Medicaid

Toll-Free: **(855) 632-7633**

Lincoln: **(402) 473-7000**

Omaha: **(402) 595-1178**

TTY: **(402) 471-7256**

Hours of operation: Monday-Friday from 8 a.m.-5 p.m. CT

Website: **dhhs.ne.gov/Pages/Medicaid-Services.aspx**

Contact DHHS for things like:

- Renewing your family's Heritage Health benefits
- Reporting a major life change
- If you become pregnant or have a baby
- Requesting a State Fair Hearing
- Getting health information and resources
- Reporting possible Medicaid fraud, waste, and abuse

Other important phone numbers

Service	Phone number
Emergencies	911
Nebrask DHHS Medicaid Eligibility **Local Lincoln area** **Local Omaha area**	(855) 632 7633 (404) 473-7000 (402) 595-1178
24-hour Nurse Help Line	(844) 782-2721
National Suicide & Crisis Lifeline	988
Nebraska 211 (resource hotline)	211
Transportation- MTM	(888) 889-0421, Monday-Friday from 8 a.m.-5 p.m. CT
Heritage Health Enrollment Broker	(888) 255-2605, Monday-Friday from 7 a.m.-7 p.m. CT
Nebraska Department of Health and Human Services	(402) 471-3121, Monday-Friday from 8 a.m.-5 p.m. CT
Nebraska Family Helpline	(888) 866-8660, 24 hours a day, 7 days a week
Division of Behavioral Health	(402) 471-8553, 24 hours a day, 7 days a week
Adult and Child Abuse and Neglect Hotline	(800) 652-1999 24 hours a day, 7 days a week
Division of Developmental Disabilities	(877) 667-6266, Monday-Friday from 8 a.m.-5 p.m. CT

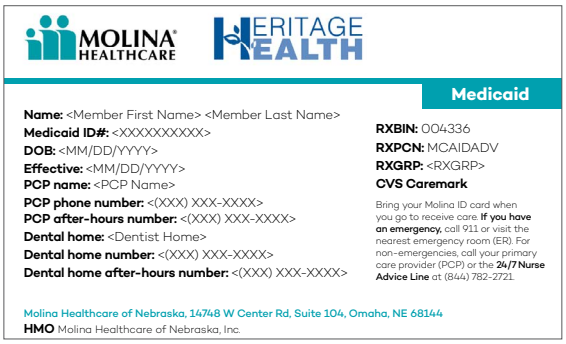
Your member ID card

When you enroll, we will mail you a Molina member ID card. You will also get a blue State Medicaid card. It is important to always carry both member ID cards with you. You should get your member ID card in the mail within 10 days of joining Molina. Each family member will have their own card. Check to make sure all the information is correct. If any information is wrong, contact Member Services at **(844) 782-2018 (TTY: 711)**. We're here Monday-Friday from 8 a.m.-6 p.m. C.T.

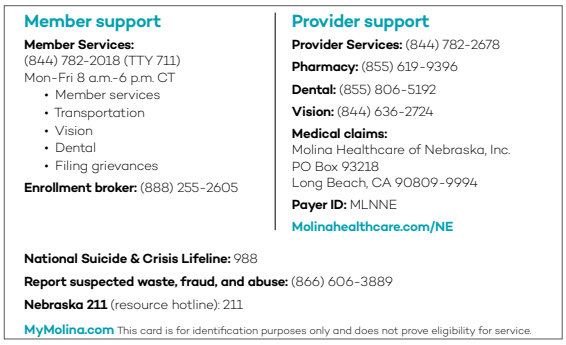
Please remember to protect your ID cards and only use them for your own care. Misuse of your ID cards, including loaning, selling, or giving it to another person, could result in the loss of your Medicaid eligibility and/or legal action.

Your Molina member ID card will look like this:

FRONT:



BACK:



Your blue state Medicaid card will look like this:

Show your member ID cards every time you need care. This includes:

- Medical appointments
- Dental appointments
- Vision appointments
- Urgent care centers
- Getting medical tests
- Hospital stays
- Emergency room (ER) visits
- Behavioral health appointments
- Prescriptions and medical supplies

If you lose your State Medicaid card, contact Nebraska Medicaid:

- Toll-Free **(855) 632-7633**
- Lincoln **(402) 473-7000**
- Omaha **(402) 595-1178**
- TTY **(402) 471-7256**

If you lose your member ID card, did not get one, or need to replace it, contact Member Services at **(844) 782-2018 (TTY: 711)**. You can also ask for a replacement using your member portal or My Molina®. You can also view your member ID card with My Molina® until you get your replacement card. Any time you receive a replacement member ID card from us, please destroy your old member ID card after you get your new one.

Enrollment

This section has information about joining and leaving our plan.

Open enrollment period

Every year, there will be an open enrollment period. During this time, you can decide to stay with Molina or choose a different health plan. Heritage Health has three plans you can choose from. Open enrollment only happens once at the end of each year.

If you want to change your health plan during open enrollment, call the enrollment broker at **(888) 255-2605**. They are available Monday to Friday, 7 a.m. to 7 p.m. You can also go to **NEHeritageHealth.com**. During open enrollment, you have the right to choose any plan. If you do not choose a new health plan, you will stay with Molina.

Renewing your benefits

Renew your family's Heritage Health benefits each year using one of these options:

1. **Online**: Log in to your ACCESSNebraska account at **accessnebraska.ne.gov**.
2. **Mail**: Fill out a renewal form and mail it back as soon as possible.
3. **Phone**: Contact DHHS Monday-Friday from 8 a.m. to 5 p.m.
   Toll-Free **(855) 632-7633**
   Lincoln **(402) 473-7000**
   Omaha **(402) 595-1178**
   TTY **(402) 471-7256**
4. **In person**: Visit your local DHHS office. Find an office near you online at **dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx**.

Major life changes

Major life changes can affect your Medicaid eligibility. It is important to let Molina and Nebraska Medicaid know when you have these life changes.

You can also report a major life change at **accessnebraska.ne.gov**.

Here are some examples of major life changes:

- Moving to a new address
- You are added to or removed from someone else's insurance
- Changing jobs
- Your ability or disability changes

- Your family got bigger, maybe because of a birth or a marriage
- Your family got smaller, maybe because a family member passed or moved away
- Changes in your income or assets
- You become pregnant
  - If you are pregnant, give us a call. We have special help for you and your baby. Contact Member Services at **(844) 782-2018 (TTY: 711)**.

Other insurance

If you have other insurance, please tell us. You should also inform Nebraska Medicaid of your change in insurance. This will help us make sure all your medical services get paid.

Workers' compensation and other claims

If you are hurt at work, workers' compensation may cover your injuries. Molina will not pay for services covered by workers' compensation.

It may take a little while to review work-related injuries. We will provide the healthcare services you need while those questions are getting answered. But before we can do this, you will need to agree to give us the information we need. We will need documents to have workers' compensation cover those services.

You should tell us if:

- You are involved in a personal injury lawsuit
- You are involved in a medical malpractice lawsuit
- You have an auto accident claim

Contact Member Services at **(844) 782-2018 (TTY: 711)** to let us know. There may be insurance coverage through other companies that will help pay for your medical services.

Disenrollment

There are times when you might be allowed to disenroll (change to another health plan). This could happen:

- During the first 90 days that you have the plan (new members)
- If you miss open enrollment due to lost eligibility
- During open enrollment

Disenrollment for cause

You can change health plans at any time for one of the reasons below.

- You move out of Nebraska
- Molina does not, because of moral or religious objections, cover the service you seek
- You need two or more services performed at the same time and Molina does not have those services available. Your PCP and another provider decide that receiving the services separately would cause you risk
- Lack of access to services covered under our health plan
- Other reasons, including but not limited to:
  - Poor quality of care
  - Lack of access to providers experienced in your health care needs

How to disenroll

You may ask to disenroll (with or without cause) in writing or by contacting the enrollment broker at **(888) 255-2605 (TTY: 711)**. They are available Monday-Friday from 7 a.m.-7 p.m. CT.

If you request disenrollment with cause, you must provide a reason. The reason must be on the list of "for cause" reasons above. If your request to change health plans is denied, you may appeal by using the State Fair Hearing process. There is more information about the State Fair Hearing process in the **Grievance and Appeals** section of this handbook.

Involuntary disenrollment for cause

Molina can also ask to disenroll you. We do this in writing through the enrollment broker. We may ask for disenrollment if at any time you:

- Misuse or loan your member ID card to another person to obtain services
- Engage in fraud, forgery, or unauthorized use of services
- Display disruptive, threatening, or uncooperative behavior toward a provider that makes them unable to cover or provide services

This does not include behavior that is because of special needs, physical, or behavioral health problems.

Molina **cannot** seek disenrollment for things like:

- Pre-existing medical conditions
- Changes in your health status
- Diminished medical capacity
- Utilizing medical services
- Refusing medical care or diagnostic testing
- Filing a grievance or appeal
- A request to change providers

Your rights and responsibilities

Molina Healthcare of Nebraska's rights and responsibilities statement

Did you know that as a Molina member, you have certain rights and responsibilities? Knowing these will help you, your family, your provider, and us ensure that you get the covered services and care that you need. These rights and responsibilities do not change your health care coverage in any way. If you have any questions about your rights or your health care coverage, please contact Member Services at **(844) 782-2018 (TTY: 711)**.

Your rights

You have the right to:

- Be treated with respect, dignity and without discrimination or retaliation
- Be given information about your illness or medical condition; understand the treatment options, risks, and benefits, and make an informed decision about whether you will receive treatment
- Participate in decisions about your healthcare including the right to refuse treatment
- Talk with your doctor and health plan and know your medical information will be kept confidential
- Choose your health plan and primary care provider
- Have access to your health plan and primary care provider
- Receive medical care in a timely manner
- Request a copy of your medical record and request changes to your medical record
- Make a complaint about a provider or Molina Healthcare, and receive a timely response
- Receive information on the medical services provided by Molina Healthcare
- Exercise your rights with a guarantee that the exercise of those rights will not adversely affect your treatment by Molina, its providers, or Nebraska Medicaid
- Change your primary care provider at any time
- Change your health plan within 90 days of initial enrollment or during the annual open enrollment period
- Have health plan materials explained or interpreted
- Have interpreters at no cost, if necessary, during medical appointments and in all discussions with your primary care provider or Molina Healthcare
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request an appeal if services are denied, terminated, or reduced
- Make advance directives, if desired, and receive assistance if needed
- Receive proper medical care 24 hours a day, 7 days a week

Member responsibilities

You have the responsibility to:

- Understand, to the best of your ability, how Molina Healthcare is used to receive health care
- Choose a provider within Molina's network
- Take your Medicaid ID card and health plan ID card to all medical appointments and to the pharmacy for prescriptions
- Keep your scheduled appointments
- Call your provider's office at least 24 hours in advance if your appointment must be rescheduled
- Tell your doctor about any medical problems
- Ask questions about things you do not understand
- Follow your provider's orders and advice
- Assist with the transfer of your medical records
- Receive services from your primary care provider or primary care dentist unless referred elsewhere by your primary care provider or primary care dentist
- Cooperate with all Heritage Health inquiries and surveys

Getting care

A primary care provider (PCP) can help you and your family stay healthy and provide preventive care. Your PCP will be your main doctor. They can help coordinate all your health needs. Every member must have a PCP. **You must see a provider who is part of our network.** If you do not choose a PCP, we will pick one for you. We'll choose a PCP based on your address, preferred language, and providers your family has seen in the past.

It is important to know that you have unlimited visits to your PCP. There is no cost to you. Make appointments with them when you feel sick. You should also have a wellness checkup every year to monitor your overall health and develop any necessary prevention plans.

Choosing a primary care provider

It is important to have a PCP who makes you feel comfortable. It is easy to choose one with our Provider Online Directory (POD), which has a list of providers. You can pick one for you and another for others in your family, or one who can see all of you. You can also contact Member Services at **(844) 782-2018 (TTY: 711)** if you need help making an appointment, finding a provider, or finding information about your PCP.

Schedule your first visit

After you choose your PCP, make an appointment for a wellness visit (general checkup). This will give you both a chance to get to know each other. It also lets your PCP get to know you when you are well, so they can better treat you when you are not. Call your PCP right away if you need to cancel or reschedule your appointment.

What to bring with you to your PCP visit

When you go to your PCP's office for your visit, be sure to bring:

- Your member ID card and State Medicaid card
- A list of any medications you are currently taking
- Any questions you want to ask your PCP

If the appointment is for your child, be sure you bring their:

- Member ID card and State Medicaid card
- Shot records
- A list of any medications they are currently taking

Primary care provider responsibilities

Your PCP will:

- Make sure you get all medically necessary services when you need them
- Follow up on the care you get from other medical providers
- Make referrals for specialty care when needed
- Give you the ongoing care you need
- Keep your medical record up to date
- Keep track of all the care you get
- Give you services in the same manner given to all their patients
- Give you regular physical exams as needed
- Give you preventive care visits
- Give you recommended immunizations
- Offer 24/7 contact information
- Discuss what advance directives are and keep them in your medical record
- Treat you with respect
- Advocate for your health
- Offer the same appointment availability to all patients
- Review all your medications and dosages at every visit

Your PCP can be a:

- Medical doctor or doctor of osteopathy with a registered specialty in:
  - General medicine
  - Family practice
  - Internal medicine
  - Pediatrics
  - Gerontology
  - Obstetrics/gynecology (OB/GYN)
- Advanced Practice Registered Nurse (APRN)
- Physician assistant (under the supervision of a physician)

Changing your PCP

You can change your PCP at any time:

- With the My Molina® app on your smartphone
- Log into your member portal at **MyMolina.com**.
- Contact Member Services at **(844) 782 782-2018 (TTY: 711)** Monday-Friday from 8 a.m.-6 p.m. CT.

If you change your PCP, we will send you an updated member ID card.

Having an OB/GYN as your PCP

Female members can see an OB/GYN in our plan for OB/GYN health needs. You do not need a referral from your PCP to see a plan OB/GYN. These services include:

- Well-woman visits
- Prenatal care
- Care for any female medical condition
- Family planning
  - You can also see a provider not in our plan (non-network) for this service
- Referral to a special provider in our plan

If you do not want to go to an OB/GYN, your PCP might be able to treat you for your OB/GYN health needs. Ask them if they can give you OB/GYN care. If not, you will need to see an OB/GYN.

If you become pregnant, please let us know as soon as possible. We can help you receive care or case management and other services.

While you are pregnant, your OB/GYN can be your PCP if they agree. Our nurses can help you decide if you should see your PCP or an OB/GYN. To speak with a nurse, contact the 24-hour Nurse Advice Line at **(844) 782-2721 (TTY: 711)**.

If you need help picking an OB/GYN, use our Provider Online Directory at **MolinaProviderDirectory.com/NE** or contact Member Services.

Newborn enrollment

If you are a Molina member when your baby is born, your baby will also be covered by our plan. Sometimes there is a waiting period to get your newborn's Heritage Health ID activated. During this time, medically necessary services are still covered. Your child's primary care provider can be a pediatrician. For more information, please see the Wellness Care for Children section.

After you have your baby, we recommend you do a couple of things right away. First, contact Member Services at **(844) 782-2018 (TTY: 711)** Monday-Friday from 8 a.m.-6 p.m. CT. Contact us as soon as you can to let us know you had your baby. We will need important details about your baby to ensure coverage right away. Then, notify DHHS so your baby can be added to your health plan.

Native American access to care

If you are a Native American or Alaskan Native, you may choose an Indian Health Service, tribal clinic provider, or Urban Indian Health Clinic as your PCP. You may get services from a tribal clinic or Indian Health Services without prior authorization. Or you can go to another Molina network provider.

Specialty care

There might be times when your PCP decides that your health needs require the skills of a specialist. You have the right to choose specialists within our network. Your PCP will help you choose a specialist and refer you. Even though Molina does not need a referral from your PCP to cover the service, the specialist might still need a referral from your PCP.

Examples of specialists are:

- Cardiologists
- Ear, nose, and throat (ENT)
- Neurologists
- Allergists
- Gastroenterologists
- Orthopedists

It is a good idea to check with Member Services to see if the provider is in Molina's network. You might need a provider that is out of our network. If this happens, contact your PCP to get prior approval from us first.

What to do if your PCP leaves our network

We will tell you if your PCP decides to leave our provider network. We will send you a notice at least 30 days before they leave. You can choose a new PCP by contacting Member Services at **(844) 782-2018 (TTY: 711)**. If you do not change your PCP, we will choose a new one for you. Once you have a new PCP, we will send you a new member ID card.

If you are in the middle of getting treatment from your PCP, we do not want to stop that treatment. You can ask to stay with your PCP for at least 30 days after they have left our network. This will give you time to finish that treatment.

We can only continue coverage if the PCP agrees. They must agree to:

- Accept payment at the rates they received as an in-network provider
- Follow the quality standards
- Provide the information we need about your care
- Follow our policies and procedures

Second opinion

If you do not agree with your provider's plan of care, you have the right to a second opinion. You can talk to another network provider. In some cases, we will arrange for you to talk to a provider outside our network at no cost to you.

Out-of-network services

If a Molina provider is unable to provide you with necessary and covered services, we must cover the needed services through an out-of-network provider. The cost to you should be no greater than it would be if the provider were in our network. This must be done in a timely manner for as long as we are unable to provide the service.

Change in benefits or providers

We might need to change your covered services or our network providers and hospitals sometimes. Your PCP's office might move or close. Nebraska Medicaid could also change the covered services that we arrange for you. If any of these changes happen, we will send you a letter telling you about changes to your plan benefits or providers.

Going to the dentist

Healthy teeth and gums are an important part of your overall health. As a Molina member you will have a Dental Home. A Dental Home is a place where children (beginning at as early as 6 months of age) and adults can get regular and thorough dental care. This is also known as your primary care dentist (PCD). A PCD can be a general dentist or a pediatric dentist. You can choose your Dental Home or Molina will assign you one. It's important that you see your PCD at least once every six months.

Your dentist will provide regular dental care that prevents problems with your teeth and gums. If you have problems with your teeth your dentist will treat you for most services. Your dentist will send you to a specialist in our network when you have dental issues that are harder to fix.

For more information on dental health and hygiene, you can visit:

- The Centers for Disease Control (Oral Health): **CDC.gov/oralhealth**
- Nebraska Department of Health and Human Services (Oral and Dental Health): **dhhs.ne.gov/Pages/Dental-Health.aspx**

What to bring with you to your PCD visit

When you go to your PCD's office for your visit, be sure to bring:

- Your member ID Card and State Medicaid card
- A list of any medications you are currently taking
- Any questions you want to ask your PCD

If the appointment is for your child, be sure you bring their:

- Member ID card and State Medicaid card
- A list of any medications they are currently taking

Dental services

Covered dental services include but are not limited to:

- Exam and cleaning every six months
- Fluoride treatments
- X-Rays every six months
- Sealants
- Fillings, extractions, and other treatments as medically necessary
- Root canals
- Periodontal treatment
- Complete and partial dentures
- Braces
- Emergencies

These services must be medically necessary. You must see a Molina dentist or an Indian Health Services provider. Some services may require prior authorization. Your dentist will contact Molina when prior authorization is required.

Changing your PCD

You can change your Dental Home at any time by contacting Member Services at **(844) 782-2018 (TTY: 711)** Monday-Friday from 8 a.m.-6 p.m. CT. If you change your PCD, we will send you an updated member ID card.

Behavioral health

We cover your behavioral health care. It is an important part of your overall health and wellness. We encourage you to talk to your PCP about your behavioral health. They can help make sure you are getting the help, care, and support you need.

We can help you:

- Deal with feelings of sadness or worries, substance use disorders, or stress
- Get an appointment with a doctor
- Get a ride to your appointment
- Get the information you need about behavioral health services
- Talk with your doctors about how you are feeling

Available services

Available behavioral health services include:

- Substance use disorder (SUD) treatment
- Outpatient services such as counseling and psychotherapy
- Help with medications
- Day treatment
- Case management
- Inpatient treatment when medically necessary (if you and your doctor feel that you cannot be safely treated in an outpatient setting)
- Certified Peer Support for mental health and substance use disorder
- Crisis intervention
- Family therapy

Prior authorization is required for some behavioral health and substance use disorder services. Please talk to your PCP about the above services or contact Member Services at **(844) 782-2018**.

For more information on behavioral health services, please see the **Covered Benefits and Services**, **Value-Added Benefits**, and **Healthy Rewards Program** sections of this handbook.

We want to give you great care!

We work with our providers to give you great care. We look at your member benefits and make choices about care based on what you need. We want you to know:

- We do not reward providers to deny care
- We do not reward staff or other people to deny care or give you less care
- We do not pay extra money to providers or our staff members to deny tests or treatments that you need to get better or stay healthy

Appointment wait times

In-network providers will be available during reasonable hours. Services will be available to meet your medical needs. You should be given an appointment within these timeframes:

Type of appointment	Scheduling time frame
Routine, non-urgent, or preventive care	Within 4 weeks
Routine, non-urgent behavioral health care	Within 4 weeks
Routine, non-urgent dental care	Within 6 weeks
Non-urgent sick care (including walk-in patients)	Within 48 hours and sooner if the illness gets worse and becomes urgent or an emergency
Urgent care (including walk-in patients)	Same day
Urgent behavioral health care	Same day
Urgent dental care	Within 24 hours of request
Urgent laboratory & X-ray	Within 24 hours (or as medically necessary)
Emergency visits	Immediately
Laboratory & X-ray	Within 3 weeks
Maternity care during the first trimester	Within 14 days of request
Maternity care during the second trimester	Within 7 days of request
Maternity care during the third trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification of high risk, or immediately in the event of an emergency
Specialists	Within 30 days of referral or sooner if needed
ER follow-up visits	Follow your discharge instructions
In-office waiting time for scheduled dental appointments	The wait should not be longer than 45 minutes. You should be told if a provider is delayed. You should be offered a new appointment if the wait is more than 90 minutes.
Family planning services	Within 7 days

If you need to cancel your appointment

Unexpected things happen that can make going to your appointment difficult. If something changes and you cannot make it, it's important to let your provider know as soon as possible. This way, others needing appointments can use that time. If you need to change an appointment, call your provider's office as soon as you can. They can make a new one for you.

Covered Benefits and Services

Molina covers many medical services. Some services must be prescribed by your doctor. All services must be medically necessary, and some must also be approved by Molina before you get the service. This is called a prior authorization.

For dental information, please see the **Going to the Dentist** section of this handbook.

Service	Coverage	Prior authorization
Allergy care	Covered.	May be required for some services
Ambulance	Covered if needed for an emergency. Non-emergency medical ambulance transportation is covered when recommended by your provider.	May be required
Asthma care	Covered.	No
Bariatric services	Covered when medically necessary.	Yes
Behavioral health services	Age limitations may apply. Services include crisis stabilization, inpatient psychiatric hospitalization, outpatient assessment and treatment services, Certified Peer Support, residential treatment facilities and rehabilitation services.	May be required for some services
Breast pumps	One per member.	No

Service	Coverage	Prior authorization
Chiropractic services	Covered when medically necessary. Medicaid limits coverage of chiropractic services to subluxation of the spine and the following services: • Certain spinal x-rays • Manual manipulation of the spine • Certain evaluation and management services • Certain therapeutic procedures, activities and techniques designed and implemented to improve, develop, or maintain the function of the area treated.	May be required
Continuous glucose monitors (CGM)	Covered when medically necessary for managing diabetes and ordered by a network provider.	Yes
Dental care	Covered for eligible members and services. Covered dental services include but is not limited to: • Fluoride applications • Sealants • Crowns • Root canal • Periodontal treatment • Complete and partial dentures • Fillings • Extractions.	May be required for some services
Durable Medical Equipment	Covered when ordered by a network provider who is a medical doctor, doctor of osteopathy, or doctor of podiatric medicine and is medically necessary Examples: • Wheelchairs, scooters, and hospital beds • Surgical appliances • Prosthetic devices • Orthotic devices • Assistive technology and medical supplies as covered by the Medical Assistance program.	May be required
Early and periodic screening, diagnosis and treatment (EPSDT)/well-child exam	Covered for all children from birth until age 21. Includes periodic screenings, multidisciplinary evaluation and treatment in children with significant developmental disabilities or delays. Annual sports and school physicals.	No

Service	Coverage	Prior authorization
Emergency services	Covered in or out of network.	No
Family planning	Women can choose family planning services from any Nebraska Medicaid participating provider, in or out of network.	No
Hearing aids and services	Covered when ordered by a network provider who is an M.D. or D.O. and is medically necessary Limited to one every four years for ages 21 and older. Batteries and medically necessary accessories covered. Hearing tests are covered.	May be required
Home health care therapy and services	Covered when prescribed by an in-network provider and medically necessary.	Yes
Hospice services	Covered when ordered by a doctor.	Yes
Immunizations for children	Available to members 18 and younger.	No
Immunizations for adults	Covered.	No
Inpatient and outpatient hospital care	Services include double-occupancy rooms, outpatient surgery, inpatient stay, blood work, x-rays, acute, inpatient rehabilitation and emergency care. Must be prescribed by an in-network provider and medically necessary.	Yes
Lab services and testing	Covered when ordered by an in-network provider and is medically necessary.	Yes
Lactation consultation	There is a limit of five counseling sessions per child, and each session can last up to 90 minutes.	No
Lead screening for children	Covered. Lead screenings can be done at the doctor's office or local health department.	No
Mammograms	Covered.	No

Service	Coverage	Prior authorization
Maternity care	Includes a minimum hospital stay of 48 hours after a vaginal birth and 96 hours after a Caesarean birth. Postpartum care and lactation services are also included. Breast pumps are covered.	May be required
Mental health and substance use services (inpatient and outpatient)	Covered.	May be required
Nutrition services	Must be prescribed by a physician or nurse practitioner and be medically necessary. The benefit is based on age and diagnosed medical conditions.	No
Nurse midwife	Must use an in-network provider.	No
OB ultrasounds	Two per pregnancy. Additional may be covered if medically necessary.	Required if more than two are needed
Office visits	Must use an in-network provider.	No
Orthotics/ prosthetics	Covered when ordered by an in-network provider and is medically necessary.	Yes
Over-the-counter (OTC) drugs	Covered with a prescription from your healthcare provider and is medically necessary.	May be required
Pap smears	Covered.	No
Physician services	One routine physical exam every 12 months performed by your PCP.	No
Podiatry (foot) care	Routine foot care, medical and surgical services from a podiatrist are covered when ordered by an in-network provider and is medically necessary.	May be required
Prescription and pharmacy drugs	Covers most drugs prescribed by your provider and medically necessary.	May be required

Service	Coverage	Prior authorization
Private duty nursing services	Covered if medically necessary and ordered by an in-network provider.	Yes
Radiology and x-rays	Must be ordered by an in-network provider and be medically necessary.	Required for high-tech radiology including CT, MRI and MRA
Reconstructive surgery	Covered if medically necessary.	Yes
Rehabilitation services	Covered if medically necessary.	Yes
Services outside of network	Covered in emergencies. All other out-of-network services require prior authorization.	Yes, excluding emergencies
Skilled nursing facility care	Covered when ordered by an in-network provider and is medically necessary.	Yes
Smoking cessation counseling	Counseling to help you quit tobacco is covered. For additional services, you may call the Nebraska Tobacco Quit Line at (800) 784-8669.	No
Sterilization services	Sterilizations require informed consent forms 30 days prior to the date of procedures.	Yes
Surgery	Covered when ordered by an in-network provider and is medically necessary. Emergency surgery is covered. Second surgical opinions are covered.	May be required
Therapy (occupational, physical and speech) services	Covered when ordered by a network provider and is medically necessary. 60 combined visits (physical, occupational and speech therapy) per calendar year for members 21 years of age and older.	Yes
Transplant services	Must be ordered by an in-network provider and be medically necessary.	Yes

Service	Coverage	Prior authorization
Vision services and eyeglasses	Under 21 years of age: One exam, lenses and frames every 12 months. Age 21 and older: One exam, lenses and frames every 24 months.	No
Yearly well-woman exams	One annual exam covered.	No

The list above does not show all your covered benefits. To learn more, contact Member Services at **(844) 782-2018 (TTY: 711)**.

Transportation benefits

You can get rides at no cost to and from your medical, behavioral health, and dental appointments. Rides must be set up at least 72 hours prior to your appointment. You can schedule transportation by:

- Contacting Member Services and requesting transportation assistance
- Contacting MTM directly at **(888) 889-0421 (TTY: 711)**, Monday-Friday, from 8 a.m. to 7 p.m.
- Using the MTM member portal
- Downloading the MTM Link Member app on your smart device

When you call or use the transportation portal, MTM will ask you:

- The address where you will be picked up. This includes the city and zip code
- The address where you will be dropped off. This includes the city and zip code
- Your telephone number
- Your Nebraska Medicaid ID number
- The name of the adult traveling with children aged 18 and under

Transportation can go to the provider you choose within 20 miles. If there is not a provider within 20 miles, they can take you to the closest provider. You can choose a provider farther away, but transportation services may not be available.

Please remember: Nursing homes are responsible for non-emergency medical transportation (NEMT) trips within a 30-mile radius of the nursing home. If you are a nursing home resident and need to see a doctor less than 30 miles from your location, your nursing home should provide the transportation.

Prior authorizations

Some services and benefits require prior approval. This is called a prior authorization. This means your provider must ask us to approve those services or benefits before you get them. We may not cover the service or drug if you do not get approval. We want to make sure that you receive the right type and number of services to help with any condition(s) you have.

Molina utilizes appropriately licensed clinical staff to conduct prior authorization reviews. Only a licensed Medical Director, Dental Director or Pharmacy Director can make a decision to deny a request. Molina does not reward providers or staff for denying requested services and we do not give incentives for prior authorization decision making.

Continuity of care: We will honor all prior authorizations previously approved prior to **January 1, 2024**, for 90 calendar days. We will do this whether an in-network or out-of-network provider requested the original authorization.

For members new to the plan through **March 31, 2024**, we will honor existing prior authorizations previously approved for medical, behavioral health, and dental services for 30 calendar days, and pharmacy services for 90 calendar days.

Maternal health service prior authorizations rules might differ. Please contact your PCP for more information.

If you would like to keep getting services from an out-of-network provider after your first 90 days with us, or if the services need a prior authorization, the out-of-network provider must ask us to approve them before you can continue getting these services.

These services do not require a prior authorization:

- Emergency services
- Post-stabilization care (care provided after emergency treatment)
- Urgent care
- Routine provider visits with in-network providers (some tests or procedures may require pre- authorization)

If we deny a request for you to get a service, these decisions are called **Adverse Benefit Determinations**. You have the right to ask us to appeal our decision. An appeal is a request for us to review a decision we made about a service that was denied, reduced, or limited. Examples include:

- Denied requested care or services
- Approved a smaller amount of a service than you asked for
- Ending a service or care that was approved before

You will get a letter in the mail telling you why we made that decision. If you do not agree with our decision, you have 60 calendar days from the date on the letter you received to ask for an appeal. You can ask to file the appeal by phone or in writing. Your provider, family member, lawyer, or other authorized representative can file an appeal on your behalf. There is an authorized representative (AOR) form available at the end of this handbook, on our website, and inside your member portal.

Hospital services

If you need to visit the hospital for a non-emergency, you must first get a prior authorization from your PCP or specialist. If you have questions about your hospital visit, please talk to the provider who referred you.

Routine care

As a Molina member, your PCP will get to know your health history, take care of your basic medical needs, and make referrals when you need them. Routine care is care that is not urgent or emergent in nature and can wait for a regularly scheduled appointment with your PCP. You should call your PCP to schedule routine care.

Non-covered benefits and services

There are times when Molina may not cover your services. These are considered either excluded or prohibited.

These services may still be covered under the Nebraska Medicaid State Plan. For more information on accessing excluded services, please contact Member Services at **(844) 782-2018 (TTY: 711)**.

Some examples of excluded services are:

- Long-term care/nursing facility services
- Intermediate care facilities for persons with intellectual/developmental disabilities
- Home and community-based waiver services
- School-based services
- Nebraska Medicaid personal assistance services
- Any service that is duplicative or determined not to be medically necessary

If you are new to Molina and receiving care from an out-of-network provider, we will cover your care for the first 180 days you are enrolled with Molina.

Prohibited services

Prohibited services are those required to treat complications or conditions resulting from non-covered services, services not reasonable and necessary, and services that are experimental and investigational unless approved by the Managed Long-Term Care (MLTC) director.

Staying healthy

Wellness care

Your health is important to us. Good health begins with enough sleep, healthy food, and healthy behaviors. That includes seeing your doctor every year (or more for children) and following their medical advice.

Wellness care for adults

Your PCP will tell you when you are due for your checkup. They will also remind you when you need certain screenings and immunizations. You can receive Healthy Rewards for completing certain preventative screenings. Please see the **Healthy Rewards** section for details.

To help you stay on top of your checkups, we might call or send you a letter. Please keep this in mind if you get a call or letter about your yearly flu shot or your child needing a health checkup. This is one way we help you and your loved ones stay healthy.

Preventive health care for adults

Preventive health care is essential. Part of preventive health care is getting your annual exams to stay healthy. At your annual exam you can discuss any health changes with your doctor, review your immunization history, and talk about any issues you may be having.

Annual women's health exam

Getting your annual women's health exam is a key part of staying healthy. During this yearly exam, your provider will:

- Review your medical and gynecological history
- Check your blood pressure, weight, and other vital signs
- Examine your body – including your skin – to check your overall health
- Perform a clinical breast exam
- Check to see if your cervix, ovaries, uterus, vagina, and vulva are of normal size, shape, and position
- Check for signs of sexually transmitted infections (STIs), cancer, and other health problems
- Perform a Pap test if needed for women at least 21 years old
- Talk with you about family planning and protection from STIs

If you haven't had your annual women's health exam, schedule one today. We can help you find a provider and make your appointment.

Annual men's health exam

Getting your annual men's health exam is a key part of staying healthy. During this yearly exam, your provider will:

- Review your medical history
- Check your blood pressure, weight, and other vital signs
- Examine your body – including your skin – to check your overall health
- Check for signs of sexually transmitted infections (STIs), cancer, and other health problems
- Talk with you about family planning and protection from STIs

Additional exams and testing that may done that are related to age and/or medical history may include:

- Check your cholesterol level
- Diabetes screening
- Colon cancer screening
- Prostate cancer screening
- Lung cancer screening
- Depression screening

If you haven't had your annual men's health exam, schedule one today. We can help you find a provider and make your appointment.

Preventive health care is also about making small changes to care for your body. Some suggestions for improving your health are listed below:

- Visit your doctor each year for your annual exam
- Go to the dentist for regular cleanings and preventive services
- Eat healthy
- Exercise
- Get enough sleep
- Manage your stress
- Don't smoke or use tobacco
- Don't use drugs or drink alcohol
- Brush your teeth at least twice a day
- Floss your teeth daily
- Drink plenty of water

Adult immunization guidelines

These guidelines are on the CDC's website. Go to **cdc.gov/vaccines/adults/**. If you have any questions about these guidelines, talk to your PCP.

Health Risk Screeners

In addition to your annual wellness exam or dental exam, you can also complete a health risk screener. Each member who completes the health risk screener will receive a $25 gift card. Set aside 15 to 40 minutes to complete this tool that asks questions about your health and your experience in getting health services.

To complete your health risk screener, you can:

- Contact Member Services at **(844) 782- 2018 (TTY: 711)**
- Fill out the health risk screener mailed in your Welcome Kit and return it using the prepaid envelope
- Fill it out on our member portal at **MyMolina.com**

Wellness care for children

EPSDT is a benefit that covers checkups and health care services for children from birth until age 21. Under the EPSDT program, children and teens enrolled in Medicaid will receive any medically necessary treatments needed to address physical and mental health conditions found during screenings.

What does EPSDT stand for?

- **Early**: Assessing and identifying problems early
- **Periodic**: Checking children's health at periodic, age-appropriate intervals
- **Screening**: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified
- **Treatment**: Control, correct, or reduce health problems found

This schedule shows when to have well-child visits. You can ask your child's doctor when they should have their next checkup.

Your child needs well-child visits when they are:

- 3-5 days old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- 30 months old
- Annually through the age of 20

Well-child checkups are important for your child's health. Your child can look and feel well but still have a health problem. During their appointment, their PCP will check their:

- Growth and development
- Ears and eyes
- Diet
- Shot records
- Test records

Immunizations can be given at well-child checkups by Vaccines for Children enrolled doctors. Immunizations can also be done at the Health Department. Below is the schedule for immunizations:

Age	Immunization
Birth	Hep B
1 month	Hep B
2 months	DTaP, Hib, IPV, PCV, rotavirus
4 months	DTaP, Hib, IPV, PCV, rotavirus
6 months	Hep B, DTaP, Hib, IPV, PCV, influenza, rotavirus
12 months	Hib, PCV, MMR, VAR, Hep A series
15 months	DTaP
4-6 years	DTaP, IPV, MMR, VAR
11-12 years	Tdap or Td, MCV, HPV (two doses)
13-18 years	MCV, HPV series (catch-up)
Every year	Influenza, COVID-19 (after 6 months of age)

Avoid lead poisoning

It's important for your child to get a blood lead test once before they turn one year old and again before they turn two years old. Children who have had lead poisoning in the past are at a higher risk. At-risk children include those who live in old homes or apartments built before 1978. High-risk and at-risk children should be tested at least once a year. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, toys, and many other places. Have your child tested for lead poisoning so they can be treated if they are positive. If lead poisoning is untreated, it can lead to disabilities and behavioral problems. This simple test will help keep your little one safe!

For more information about lead poisoning, visit the Department of Health and Human Services (DHHS) website at **dhhs.ne.gov/lead**.

Care for pregnant members

We want to make sure you get medical care as soon as you think you are pregnant. If you think you are pregnant, see your PCP. If you are pregnant, your PCP will want you to see an OB/GYN. It is important that you see an OB/GYN. You don't need a referral to see one.

When you find out you are pregnant, please give us a call so we can discuss resources and value-added benefits with you. We are here to guide you through this exciting time. You should also report your pregnancy to the DHHS.

When you are pregnant, remember to:

- See your PCP or OB/GYN throughout your pregnancy
- Go to all your visits when your PCP or OB/GYN tells you to
- Go to your provider after you have your baby for follow-up (postpartum) care (between 7 to 84 days after your baby is born)
- Choose a pediatrician for your baby before birth
  - If you do not choose a pediatrician, we will choose one for you

There are things you can do to have a safe pregnancy. Talk to your doctor about medical problems you have – like diabetes or high blood pressure. It is important to have healthy habits while you are pregnant. This includes exercising, eating balanced meals, and sleeping 8-10 hours a night. These things can help you and your baby stay healthy. Using tobacco, alcohol, or drugs while you are pregnant may harm your baby.

You should see your doctor before planning a pregnancy if you have had the following:

- Three or more miscarriages
- Preterm birth – also known as premature birth – which is the birth of the baby at fewer than 37 weeks of gestational age
- Stillbirth: A stillbirth is the death or loss of a baby before or during delivery

After you have your baby, we recommend you do a couple of things right away. First, contact Member Services at **(844) 782-2018 (TTY: 711)** Monday-Friday from 8 a.m.-6 p.m. CT. Contact us as soon as you can to let us know you had your baby. We will need important details about your baby to ensure coverage right away. Then, notify DHHS so your baby can be added to your health plan.

For additional pregnancy resources, please see **Community Resources** in this handbook.

Transitions of care

Making sure that you get the care you need is very important to us. We will do our best to make sure you keep getting services when there are events in your life or transitions that impact you and the services you have been receiving. This may include:

- When you are leaving another health plan and just starting with us,
- When one of your providers leaves our network and you need to transition to another provider,
- When you leave our plan to go to another health plan.
- When you are entering adulthood and need help choosing a new doctor, or
- When you are discharged from a facility (such as a hospital or nursing home) to home or to another level of care.

We have a program that can assist you with that transition and get you the help you need. Contact Member Services at **(844) 782-2018 (TTY: 711)** if you have questions or want to learn more.

Pharmacy

Prescriptions

You get prescription drugs at no cost to you. We cover your medically necessary and prescribed drugs. We also cover some over-the-counter (OTC) drugs with a prescription from your provider. See the section Over-the-counter drugs to learn more.

Generic drugs are drugs that have the same dosage, safety, strength, and intended use as a brand-name drug. They usually cost less than brand-name drugs. We cover all drugs covered by Nebraska Medicaid or on the Molina supplemental formulary. Nebraska Medicaid uses a Preferred Drug List (PDL). The PDL includes both generic and brand-name drugs. It also gives you facts about a drug and lists any restrictions.

It is important to remember that our PDL can change. You can check the PDL when you need to fill or refill a medicine.

Drugs on the PDL are covered by Molina. Non-preferred and some preferred drugs may require a prior authorization or meet certain requirements for coverage. The Nebraska PDL may be found under the **Pharmacy** section at **MolinaHealthcare.com/NE**.

Most drugs are covered up to a 30-day supply. Some maintenance drugs offer up to a 90-day supply. If the drug requires a prior authorization, you may be able to receive an emergency supply of the medication while the prior authorization is being reviewed.

Some drugs have limits, or rules, on their use due to cost, safety, and other reasons. These might include:

- **Quantity limits**: Limits the amount of the drug you can fill or refill at a given time or interval
- **Step therapy**: Requires that you try a certain drug, such as a generic, before your provider can prescribe another drug
- **Prior authorization**: Means your provider must get approval from us before prescribing a drug

Some reasons for a prior authorization include:

- Needing a drug that is non-preferred on our PDL
- The drug is being used for a health condition the Food and Drug Administration (FDA) does not approve
- The prescription is being refilled too soon (quantity limits)
- There are other drugs you must try first (step therapy)
- There is a generic or alternative drug available
- The drug possibly being misused or abused

To get approval, your provider must tell us the medical reason you need the drug and quantity. We will work with your doctor to help you get the drugs that are best for you. If we do not approve the prior authorization request, we will send you a letter. The letter will explain how to file an appeal. It will also tell you about your right to a State Fair Hearing. Learn more about appeals and State Fair Hearings in the **Grievance and appeals** section.

OTC drugs

We cover some OTC drugs with a prescription from your provider. Please check our PDL and our covered OTC list on our website **Molinahealthcare.com/NE** under the **Pharmacy** section.

Please use an in-network pharmacy to fill your prescriptions. You can find in-network pharmacies using the Pharmacy Locator on our website. Be sure to take your member ID card with you and remember to fill your prescriptions before you travel out of state.

Other benefits

Value-added benefits

Molina offers additional benefits to support your health and wellness.*

Program	Value-added benefit	Description	Eligible populations
Smoking cessation	Smoking cessation products	This benefit provides up to $185 gift card for qualified members to be used for over-the-counter tobacco cessation products.	Eligible members at least 18 years old, or pregnant women of any age
WW® (formerly Weight Watchers)	$45 value for WW® membership	Eligible members can receive up to 13 weeks of WW® services. Members can be referred by providers, internal departments (e.g., case managers), or a self-referral.	All members

Program	Value-added benefit	Description	Eligible populations
Personal care and household items	$30 per member household, per quarter	Member household receives $30 per quarter for commonly used personal care and household items.	All members
Pregnancy: Text4baby	Healthy baby text education program	Text4baby helps prepare members for motherhood by sending appointment reminders and useful information to new moms.	Pregnant members and members with children under one year of age
Pregnancy: Baby shower	A Pack 'n Play® or a month's supply of diapers for attending members	A fun, educational event for pregnant members and new moms where they will learn about keeping themselves and the baby healthy during and after pregnancy.	Pregnant members
Pregnancy: Doula services	Total of eight visits for doula assistance services (prenatal, postpartum and delivery assistance)	Eligible members (members who are at high risk and members of a group experiencing health disparities) can request doula assistance during labor and delivery to provide emotional and physical support to the mother and her family.	Members meeting high-risk criteria
Pregnancy: Car seats	A car or booster seat for completing prenatal visits	Complete a prenatal visit during their first trimester or within 42 days of enrollment.	Pregnant members
Pregnancy: Meals	Home-delivered meals for pregnant and postpartum members	Members can request home-delivered meals that can support their nutritional needs during pregnancy and while breastfeeding.	Members who are pregnant or in the first year of post-partum
Pregnancy: Pacify	Gift box for mom and baby	Members who sign up for Pacify – our online pregnancy and postpartum support tool – are eligible to receive a gift box that includes fun items for mom and baby.	Pregnant members

Program	Value-added benefit	Description	Eligible populations
Pregnancy: Electric breast pump	Breast pump	New mothers with an infant who would like to get a no-cost electric breast pump.	Pregnant or new moms
Pregnancy: Dental services	One additional cleaning for pregnant moms	Pregnant women can receive an additional cleaning during pregnancy.	Pregnant members
Membership fees	YMCA, local Boys & Girls Club and Salvation Army Kroc Center membership fees	To assist young members in developing social and leadership skills.	Members between the ages of 6-18
Transportation	Additional transportation	Members can get transportation to certain non-medical locations and social determinants of health (SDOH) resources like WIC appointments, the pharmacy, grocery store and more.	Members participating in care management
TruConnect	No-cost phone with Molina apps	The service plan – supported by TruConnect – includes no cost or discounted wireless devices and unlimited talk and text.	Members who qualify for the federal Lifeline program
Home-delivered meals	Home-delivered meals for high-risk transitions of care	Molina will provide a box of healthy food to members with high-risk conditions such as diabetes or high-risk pregnancy and who are experiencing food insecurity.	High-risk members with chronic conditions, including members with high-risk pregnancies
GED testing support	GED test and test preparation support	Gift card to pay GED test fees at authorized testing centers ($134 value) and test preparation materials.	Members at least 18 years old

Program	Value-added benefit	Description	Eligible populations
Community resources	Molina Find Help access	Community resource referral support platform that gives members on-demand, 24/7 access to thousands of community resources across the state.	All members
My Molina mobile app	My Molina	My Molina provides members with a variety of resources like their benefit information, access to their member ID card, a list of their medicines and so much more.	All members
24-hour Nurse Advice Line & Behavioral Health Crisis Line	Toll-free 24-hour Nurse Advice Line	Access to our 24-hour Nurse Advice Line and Behavioral Health Crisis Line, available 24 hours a day, 7 days a week, 365 days a year.	All members
Dental exams: Problem-focused	Two additional problem-focused oral exams	Two additional problem-focused oral exams to supplement existing Medicaid dental benefits.	All members
Client Assistance Program (CAP)	Behavioral health therapy	Five sessions of brief solutions-focused behavioral health therapy.	All members
All members	Annual sports physical	Qualifying members can get one annual sports physical at no additional cost.	Members between the ages of 3-17
Healthy Minds, Healthy Kids	Arts and literacy support for school-aged members	$50 gift card for books or art supplies to encourage fun activities and less screen time.	Kindergarten-12th grade-aged children

Healthy Rewards program

Preventive care	Reward	Description	Eligible populations
Well-child visits	$10 gift card per well-child visit	Complete up to six well-child visits on time within a 15-month period.	Members up to 15 months old
Well-child visits	$25 gift card for well-child visits	Complete two or more well-child visits when the child is between 15-30 months old.	Members between 15-30 months
Well-child visits	$25 gift card for well-child visits	Members between 3-17 years old must complete an annual well-child visit.	Members between 3-17 years old
Adult preventive screening	$25 gift card for adult preventive screening	Complete annual adult preventive screening (wellness) visit (limited to one per year).	Members at least 18 years old
Health risk screening	$25 gift card for health risk screener completion	Complete initial health risk screener and annual health risk screener – (limited to one per enrollment year).	All members
Hospital follow up: Behavioral health	$50 gift card for behavioral health inpatient follow-up visit	Complete a follow-up visit with a behavioral health provider within seven days of inpatient hospitalization for mental illness (includes telehealth).	All members
Hospital follow up: PCP	$50 gift card for PCP follow-up visit	Complete a follow-up PCP visit within seven days of an inpatient hospitalization or behavioral health stay (includes telehealth).	All members
Diabetes: Vision screening	$50 gift card for diabetes eye exam $50 gift card for HbA1c lab work ($100 maximum annually)	Get yearly diabetic retinal eye exam and complete HbA1c lab work.	Members ages 18-75 who are diagnosed with diabetes

Preventive care	Reward	Description	Eligible populations
Postpartum visit: Care Connections in-home visit	$25 gift card for a timely postpartum visit	For new moms that complete timely postpartum exams.	New moms
Mammogram screening	$25 gift card for mammogram	Complete an annual mammogram screening.	Female members between the ages of 40-74
Cervical cancer screening	$25 gift card for cervical cancer screening	Complete an office visit for cervical cancer screening (Pap test).	Female members between the ages of 16-64
Chlamydia screening	$25 gift card for chlamydia screening	Complete an annual chlamydia screening.	Female members between the ages of 16-64

* All value-added benefits and rewards may have exclusions or limits. Members must have Molina Healthcare of Nebraska Medicaid as their primary insurance at the time of service to qualify for value-added benefits and rewards.

Member resources

Care management

Care management is a set of supports to help you access medical, behavioral, dental and/or social services. Care management helps to improve your health and wellness. Examples include:

- Assistance with health risk screening,
- Coordination of transportation to medical, behavioral, and dental appointments,
- Providing you with health care reminders,
- Assisting with transition of care from one setting to another, like leaving the hospital,
- Connecting you with community resources, housing assistance, and employment assistance,
- And access to value-added benefits.

Case management

Case management is a program provided to members whose health or social situation warrants additional support to attain their personal health goals. Members who are candidates for case management include, but are not limited to:

- Members with complex medical or behavioral conditions (including substance use disorders)
- Members who have health conditions, including chronic conditions that would benefit from case management
- Foster members (including members aging out of foster care)
- Members involved in the justice system

- Members with Medicare and Medicaid
- Members with intellectual or developmental disabilities,
- Members who self-identify as homeless or medically complex (These forms were sent in your Welcome Kit. You can also find them in your member portal, on our website at **MolinaHealthcare.com/NE**, or on the DHHS website at **dhhs.ne.gov/Pages/Medically-Complex.aspx**)
- Members referred from a provider
- Members who self-refer for case management

Participation in case management is voluntary. Members enrolled will be assigned a case manager to help them reach their health care goals. The case manager will complete a needs assessment and assist the member in developing a personalized care plan. The case manager will meet with the member on a frequency consistent with their needs. The case manager can help the member with coordination of care, access to providers/services, assistance with obtaining medically necessary equipment/supplies, and provide education on health conditions, medications, and treatment plans.

Care plans

If you are enrolled in case management, you and your case manager will create an individualized care plan that includes the types of health services that you need, how you will get them, as well as your personal goals for your health. Goals are developed based on a comprehensive health risk assessment, and your personal needs and goals. Your care team will work with you to review and update your care plan as you work towards meeting your goals, when your health care needs change, and at least once per year.

Once your care plan has been created, your case manager will send you a copy and send a copy to your PCP. You can also find your care plan, if applicable, in your health record in your member portal. Your care plan will include the goals that you created with your case manager as well as the steps you will take to help meet your health care needs.

Disease management

In addition to case management, Molina offers a disease management program for members who have lower risk chronic health conditions. The goal of the program is to help members achieve wellness and self-management. This is achieved through member education, helping members find supports and resources and assisting members in accessing needed benefits. Members may receive educational materials by mail and may opt for telephone-based health coaching which includes nurses, dieticians, and health educators.

Examples of disease management programs include: Asthma, Diabetes, Heart Failure, Depression, Chronic Obstructive Pulmonary Disease, Hypertension (high blood pressure), Tobacco Cessation, Weight Management, and Nutritional Counseling.

Duration of the program for telephone-based coaching is usually 60 days or less and is based on a member's needs. If a member develops more acute care needs or has on-going needs, they may be assigned to case management for continued support.

MolinaHelpFinder.com – powered by Aunt Bertha

This is a no cost and confidential 24/7 service that will help you find local resources.

24-hour Nurse Advice Line

Contact **(844) 782-2721 (TTY: 711)** 24 hours a day, 7 days a week when you need medical advice and don't have time to go to the doctor.

Member portal – MyMolina.com

Connect to our secure portal from any device, wherever you are, and manage your health plan online 24 hours a day, 7 days a week. Change your primary care provider, update your contact information, request a member ID card, and more! To sign up, go to **MyMolina.com**. It is easy to use and lets you take care of your health care online.

With My Molina, you can:

- Print your member ID card
- Request a replacement member ID card if you have lost yours
- Change your primary care provider
- Check your eligibility
- Update your contact information
- Get reminders for health services that you need

You can also view:

- Your history of services such as doctor visits
- Info and resources to help you and your family stay healthy
- Services offered for members only

Sign up and log in today!

Just follow these easy steps:

Step 1: Go to MyMolina.com

Step 2: Enter your member ID number, date of birth, and zip code

Step 3: Enter your email address

Step 4: Create a password

That's it! Now you're ready to log in and use My Molina!

Forgot your password?

Click on Forgot my Password and go through the steps to reset it.

Community resources

We are part of your community. We work hard to make it healthier. Local resources, health events, and community organizations are available to you. They provide great programs and convenient services. Best of all, most of them are available at no or a low cost to you.

Nebraska 211: A one-stop source of information for people in need of assistance. Nebraska 211 connects community members in need to resources that can help. Go to ne211.org to learn more.

Help to quit smoking: Free, confidential help to quit smoking or using tobacco:

- I Want to Quit Tobacco (**ne.gov**)
- Tobacco Free Nebraska: **(800) QUIT-NOW (784-8669)**

Pregnancy resources

March of Dimes: Fights for the health of all moms and babies. Go to **marchofdimes.org**.

Staying healthy during pregnancy: Nebraska state information and resources for your pregnancy. Go to **dhhs.ne.gov/Pages/During-Pregnancy.aspx**

Text4baby: Visit **text4baby.org** for information about how to keep you and your baby healthy at each stage of your pregnancy and through the first year of your baby's life.

Other services

Nebraska Department of Health and Human Services (dhhs.ne.gov)

- Women, Infants, and Children (WIC) aims to protect the health of qualifying at-risk low-income women, infants, and children up to age 5 by giving nutritious foods, information on healthy eating and health care referrals
- Supplemental Nutrition Assistance Program (SNAP) gives food benefits to low-income families so they can afford nutritious food essential to health and well-being

Behavioral health crisis line

If you or someone in the home is in the act of harming themselves or harming someone else, please call **911** immediately. If you are having behavioral health distress or have thoughts about harming yourself or someone else:

- Contact us at **(844) 782-2018 (TTY: 711)**. Molina operates a behavioral health crisis line. Trained behavioral health clinicians are available to assist you 24 hours a day, 7 days a week.
- You can also get help right away by calling the National Suicide Lifeline by dialing 988
  - 988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can get free and confidential support 24 hours a day, 7 days a week, 365 days a year by dialing 988 from any phone.
- Go to the closest hospital for emergency care
- For other resources and support contact the Nebraska Family Helpline:
  - **dhhs.ne.gov**
  - **(888) 866-8660 (TTY: 711)** (available 24 hours a day, 7 days a week)

After-hours and emergency care

After-hours care

If you need care after normal business hours, contact your PCP. All PCPs have coverage for their patients 24 hours a day, 7 days a week. Your PCP may have an answering service where someone can help you with your medical issue or they can call your PCP to discuss your options for care.

Sometimes your PCP may have another PCP cover for them either after hours or if your PCP is out of the office. They could give you advice over the phone and sometimes prescribe a medication. You might be asked to visit the PCP or be sent to an urgent care center.

Molina also has a Nurse Advice Line with highly trained nurses. They can help you decide if you or your child should seek medical attention right away. You can call the Nurse Advice Line at **(844) 782-2721 (TTY: 711)** and talk to a nurse, 24 hours a day, 7 days a week.

If you have a medical emergency, call 911 or go to the nearest emergency room (ER). If you are having a behavioral health crisis, call 988, or go to the nearest ER.

Emergency care

An emergency is a medical problem that needs to be treated immediately. Molina covers emergencies wherever you are. You do not have to call us for approval in an emergency. Call **911** or go to the nearest ER. This includes a facility that is not in our network. You can get emergency care 24 hours a day, 7 days a week.

Some examples of an emergency are:

- Miscarriage or pregnancy problems
- Seizures or convulsions
- Unusual or excessive bleeding
- Unconsciousness
- Overdose/poison
- Severe pain
- Severe burns
- Trouble breathing
- Chest pains

Please carry both your member ID card and State Medicaid card with you at all times. If you are told you need to stay in the hospital, the hospital will contact us to let us know. If you are asked to stay in a hospital that is out of Molina's network, we will transfer you to a hospital that is part of Molina's network as soon as you are well enough to be moved. If the ER doctor decides that you do not have to stay, but you decide to stay, you may be responsible for the cost of your stay.

Once you leave the ER, do not return to the ER for follow up care. Make an appointment with your PCP or specialist.

If you are not sure if you need emergency care, contact your PCP or our toll-free 24-hour Nurse Advice Line.

ERs are only for real emergencies. They are not good places to get non-emergency care. They are often very busy and must care first for those whose lives are in danger. Please do not go to an ER if your condition is not an emergency.

Post-stabilization care

Post-stabilization care is any covered service you may need due to an emergency medical condition. These services would be provided to you after your condition has been stabilized to improve, sustain, or resolve your condition. You will not be held responsible for payment for screening services or the treatment services that may be needed to stabilize or diagnose an emergency medical condition. We will work with the provider if prior authorization for post-stabilization services is needed. These services are covered regardless of whether the provider is in our network or not.

Getting care out of state

If you are outside of Nebraska and need emergency care, go to the nearest ER. Please contact us within 24 hours, or as soon as you can, so you can follow up with a Molina network provider.

You may also receive out of state care from an urgent care clinic or doctor's office by showing your Molina member ID card and your Nebraska Medicaid card. Contact us as soon as you can to let us know you have received care out of state.

Molina only covers services received within the United States.

Urgent care

Urgent Cares are a great option if you need after-hours care. Some examples of when to use the urgent care center include:

- Severe cold or flu symptoms
- Ear pain
- Sore throat
- Stomach flu or virus
- Wounds that need stitches
- Sprains, strains, or deep bruises

If you need help locating an urgent care in your area, please visit our Provider Online Directory at **MyMolina.com** or contact Member Services.

24-hour Nurse Advice Line

We have registered nurses to take your call 24 hours a day, 7 days a week – at no cost to you! Contact us at **(844) 782-2018 (TTY: 711)** when you are not sure how to handle a health-related problem. They will help you decide what kind of care you need.

You can get help with things like:

- Back pain
- A cut or burn
- A cough, cold, or the flu
- Dizziness or feeling sick to your stomach
- A sick or crying baby

When you call, a nurse will ask questions about your symptom(s). Give as many details as you can. For example, describe where it hurts or what it looks and feels like. They can then help you decide if you:

- Can care for yourself at home
- Need to see a doctor or go to an urgent care or the hospital

Telehealth services

Telehealth is a convenient way to get care for common illnesses without having to go to the ER or urgent care. For non-emergency issues – including the flu, allergies, rash, upset stomach, and more – you can connect with a doctor through your smartphone or computer to get care wherever you are, whenever you need it. Doctors can diagnose, treat, and even prescribe medicine if you need it. Contact your doctor's office to see if they offer telehealth services.

Other insurance and bills

What to do if you get a bill

Molina has a list of services that are covered. These are the services we pay for when they are medically necessary. This list has been approved by the Department of Health and Human Services.

Talk with your provider about covered and non-covered services. When you follow the plan rules, you should not be billed for covered services.

When you schedule treatment:

- Show both your member ID card and Nebraska Medicaid ID card at every appointment.
- Ask the provider if they are in network with Molina Healthcare of Nebraska. If they say no, contact us right away.

If you have both Medicaid and Medicare, you cannot be billed for Medicare cost-sharing. This includes deductibles, coinsurance, and copayments that are covered by Medicaid.

Contact Molina and your provider as soon as you can if you get a bill for a service you believe should be covered by Molina. Do not pay any bill that you get. Molina cannot pay you back if you do so.

Other plan details

Advance directives

All adult members have a right to say yes or no to medical treatment. An advance directive protects those rights. It helps you to plan for future treatment decisions ahead of time. It informs people what you want if you cannot make your own decisions. Your doctor can talk about these options with you before you have an emergency. If you ever have a medical emergency and cannot communicate what you need, your doctors will already know what to do.

Examples of common types of advance directives include:

A living will or declaration. A living will informs your health care providers and family the kind of medical care you want or do not want if you cannot make your own decisions. In Nebraska, the Rights of the Terminally Ill Act ensures that an adult of sound mind may execute at any time a statement governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the individual or another person at the individual's direction and witnessed by two adults or a notary.

Treatments could include:
- Feeding tubes
- Breathing machines
- Organ transplants
- Treatments to make you comfortable

If you want to sign a living will, you can:
- Ask your PCP for a living will form.
- Fill out the form by yourself or call us for help.
- Take or mail the completed form to your PCP or specialist. Your PCP or specialist will then know what kind of care you want to get.

A durable power of attorney for health care (DPAHC). This lets you choose someone to make health care decisions for you when you cannot make them yourself. This trusted person follows the instructions you give. The power of attorney must have clear dates for when it starts and ends. It must also be witnessed and signed by two adults or signed and acknowledged for you by a notary.

A do not resuscitate (DNR) order. This tells health care providers not to give you cardiopulmonary resuscitation (CPR) if your heart and/or breathing stops. A DNR order is only about CPR. It does not provide instructions about other treatments.

Ask your provider or contact Member Services to find out more about advance directives.

Please contact Nebraska DHHS at (800) 254-4202 to file a complaint if your provider does not comply with advance directive requirements or if your advance directive was not followed.

Quality Improvement plan and program

We are committed to making sure you get the best care possible. That is why we put a plan in place every year to keep improving:
- Our services
- The quality of care you receive
- The way we communicate with you

Our goals are to:
- Give you services that benefit your health
- Work with providers to get you the care you need
- Address your language and cultural needs
- Reduce any barriers to getting care
- Improve the health of our members

We also want to hear how we are doing. We review the past year of services to check our progress. We might send you a member survey to get your feedback.

We might also send surveys to see how many members get the services they need. These surveys tell us what type of care is needed. One of these surveys is the Consumer Assessment of Healthcare Provider and Systems (CAHPS®) survey.

This survey asks questions about how you rate:

- Your health care
- Your PCP
- Your health plan
- Specialist(s) you have seen
- Well-check exams
- How easy it is for you to get care
- How easy it is for you get care quickly

Healthcare Effectiveness Data and Information Set (HEDIS®)

We also measure how many of our members get key tests and exams. We look at:

- Annual exams
- Diabetes care
- Mammograms (X-rays of the breast)
- Medicine management
- Pap tests
- Prenatal care
- Postpartum care
- Shots (flu, child, and teen shots)

We care about your health. We want you to help take better care of yourself and family. To do this, we:

- Remind you to get well-check exams and shots
- Teach you about chronic health problems that you may have
- Make sure you get prenatal and postpartum care if you are pregnant
- Remind you to get Pap tests and mammograms, if needed
- Address any complaints you have
- Help you find and use information on our website
- Tell you about special services we offer

To learn more, contact Member Services at **(844) 782-2018 (TTY: 711)**. We are here Monday-Friday from 8 a.m.-6 p.m. CT. You can ask for a printed copy of our quality improvement plan and results.

Guidelines to keep you healthy

We give you information about preventive services and when to get them. The information does not replace your doctor's advice.

To make the most of these guidelines:

- Take time to read them.
- Write down questions and bring them to your next checkup.
- Tell your provider about any health problems you or your children are having.
- Go to your appointments
- If you miss an appointment, reschedule right away.
- We tell you about key tests and exams for issues like diabetes.

Member Advisory Committee (MAC)

We aim to give members ongoing chances to give feedback on the plan, services, and offerings, and to voice their interests and needs. Our community engagement team holds quarterly meetings with members and stakeholders to keep a pulse on our members' opinions. These meetings are an opportunity for Molina to connect directly with members on a variety of topics of interest.

If you would like to join, please contact Member Services. They can give you information about joining the MAC or Quality Improvement Committee.

Reporting alleged marketing violations

Nebraska DHHS has rules for how health plans can interact with people who are not their members. Molina works hard to follow these rules.

Activities that are not allowed include:

- Marketing directly to Medicaid enrollees or potential Medicaid eligible individuals. Direct marketing includes direct mail advertising, unsolicited email ("spam"), and door -to-door, telephonic, or other "cold call" marketing techniques
- Providing promotional giveaways to persons not currently members
- Portraying competitors or potential competitors in a negative manner
- Implying that joining a particular MCO is the only means of preserving or obtaining Medicaid services
- Assisting with enrollment or improperly influencing MCO selection
- Helping someone choose a health plan
- Comparing themselves to other health plans by name
- Charging members for items or services at events
- Using terms that would influence, mislead, or cause potential members to contact the MCO, rather than the MLTC-designated enrollment broker, for enrollment

If you see any health plan breaking these rules, you can report this behavior to Nebraska DHHS at (800) 727-6432 or ago.medicaid.fraud@Nebraska.gov.

Important terms

Abuse: Harming someone on purpose (includes yelling, ignoring a person's need, and inappropriate touch).

Advance directive: A decision about your health care that you make ahead of time in case you are ever unable to speak for yourself.

Adverse benefit determination: The denial, limitation, or termination of a requested service.

Appeal: An appeal is a request for a review of an action. You or your authorized representative can request an appeal following a decision made by Molina.

Authorization: An approval for a service.

Benefits: Services, procedures, and medications that Molina will cover for you.

Case management: Case management helps you manage your complex health care needs. Case managers can help with the coordination of benefits or with accessing other social services as needed.

Chronic condition: A chronic condition lasts one year or more and requires ongoing medical attention, limits daily living, or both.

Copayment (copay): Some medical services have a copay, which is your share of the cost. If there is a copay, you will pay it to the provider. The provider will tell you how much it is.

Dental Home: Your chosen main provider for dental care and services.

Durable medical equipment (DME): DME is medical equipment like wheelchairs, walkers, and IV poles that are used in the home. You will rent or own it and it's ordered by a provider. It can also be equipment that must be thrown away such as bandages, catheters, and needles.

Emergency (non-life-threatening mental health): When symptoms first develop, but are not life-threatening, like suicidal ideation without a plan to implement or signs of mania or psychosis.

Emergency medical condition: An emergency medical condition is any condition that you believe endangers your life or would cause permanent disability if it is not treated right away.

If you have a serious or disabling emergency, you do not need to call your provider or Molina. Go directly to the nearest ER or call an ambulance.

Emergency medical transportation: Emergency medical transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency room (ER) care: ER care is provided for emergency medical conditions.

Emergency services: Emergency services are provided when you have an emergency medical condition.

Excluded services: Excluded services are services that Medicaid does not cover. You might have to pay for these services.

Fraud: An untruthful act (e.g., if someone else uses your member ID card and pretends to be you).

Grievance: A grievance is an expression of dissatisfaction about any matter other than a decision.

Health information: Facts about your health and care. This information might come from us or a provider. It includes information about your physical and mental health, as well as payments for care.

Health insurance: A type of insurance coverage that pays for medical and surgical expenses incurred by the insured.

Health risk screener: A health risk screener is a short survey with questions about your health.

Hospice services: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life rather than a cure.

Hospital inpatient care (or hospitalization): Care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery, or having a baby.

Hospital outpatient care: Hospital outpatient care is when you get hospital services without being admitted.

ID card: An identification card that says you are a Molina member. You should always have this card with you.

Immunization: A shot that protects you from disease. Children should get specific ones at specific ages. Shots are often given during regular doctor visits.

Informed consent: Confirmation that all medical treatments have been explained to you and you understand and agree to them.

In-network: Doctors, specialists, hospitals, pharmacies, and other providers who have an arrangement with us.

Medically necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Member: A person who is eligible for Heritage Health and Molina benefits and services.

Network: Molina has a network of providers across Nebraska that you can see for care. You do not need to call us before seeing one of these providers.

Out-of-network: Doctors, specialists, hospitals, pharmacies, and other providers who do not have a contract with Molina to provide health care services to members.

Over-the-counter (OTC) medications: Medicines or drugs that can be bought without a prescription. Molina covers many OTC medications that are on the state's approved list. A provider must write you a prescription for the OTC medication you need.

Physician services: Physician services are necessary medical services performed by doctors, physician assistants, and nurse practitioners.

Plan: Molina is your health plan which pays for and coordinates your health care services.

Prescription drug coverage: Molina provides prescription drug coverage by paying for your prescription drugs.

Prescription drugs: Drugs that – by law – need a prescription written by a doctor with instructions for use.

Primary care dentist (PCD): A PCD is a general or pediatric dentist you see for care.

Primary care provider (PCP): A PCP is either a physician, physician assistant, or nurse practitioner who directly provides or coordinates your health care services. A PCP is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

Prior authorization: The process that your doctor uses to get approval for services that need to be approved before you can get them.

Provider: A provider is a health care professional who offers medical services and support.

Provider directory: A list of providers who participate with Molina to help take care of your health care needs.

Referral: When your PCP determines that you need to see another doctor and they send you to a specialist in our network.

Self-referred services: Services for which you do not need to see your PCP for a referral.

Specialist: Any doctor who has special training for a specific condition or illness.

Substance use information: Facts about your substance use and care. This information might come from us or a provider. It includes information about your substance use history and current use and payments for care.

Urgent care: Urgent care is needed when you are not in a life-threatening health situation but need treatment or medical advice within 48 hours.

Women, Infants, and Children (WIC): Supplemental food program for women, infants and children that provides nutrition counseling, nutrition education, and nutritious foods to pregnant and postpartum women, infants, and children up to two years old. Children deemed nutritionally deficient are covered up to five years old if they are low-income and determined to be at nutritional risk.

Fraud, waste and abuse

Molina is committed to preventing, identifying, and reporting all instances of suspected fraud, waste and abuse. Fraud, waste, and abuse means that any member, provider, or person is misusing the Nebraska Medicaid program or Molina's resources.

Fraud

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

Waste

Waste is health care spending that we can eliminate without reducing the quality of care.

Abuse

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

Our fraud, waste and abuse plan supports Molina, its employees, members, providers, payers, and regulators. The plan helps by increasing efficiency, reducing waste, and improving the quality of services.

- We take the prevention, detection, and investigation of fraud, waste, and abuse seriously.
- We comply with state and federal laws.
- We investigate all suspected cases of fraud, waste, and abuse. We promptly report them to government agencies when needed.
- We take the appropriate disciplinary action. This might include termination of employment, provider status, and/or membership.
- You can report potential fraud, waste, and abuse without giving us your name.

Examples of health care fraud, waste and abuse by a member or provider include:

By a member:

- Using someone else's health insurance card
- Forging or altering a prescription
- Giving misleading information
- Leaving out information on an application for health care coverage, including intentionally giving incorrect information in order to get benefits

By a provider:

- Falsifying documents in order to get services paid
- Altering records in order to get services paid
- Billing for services or goods not provided to the member
- **Unbundling**: When a provider bills parts of the service separately when they should have been billed together as one service
- **Upcoding**: When a provider bills for complex care when it was not complex

- Billing for services that are not medically necessary
- Billing for more units than what was provided
- **Balance billing**: Asking the member to pay the difference between what Molina paid to the provider versus what the provider billed to Molina
- **Kickbacks or bribes**: Knowingly and willfully asks for or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid members
- **Stark Law Violation**: Knowingly and willfully referring Medicare or Medicaid patients to health care facilities that the referring provider has a financial relationship with

Here are some ways you can help stop fraud:

- Do not give your member ID card, medical ID card, or ID number to anyone else. Only give them to a health care provider, a clinic or hospital when getting care. You should also:
  - Never let anyone borrow your member ID card
  - Never sign a blank insurance form
  - Be careful about giving out your Social Security number

How to report

How to report suspected fraud, waste and abuse

To report suspected fraud, waste and abuse or neglect in the Nebraska Medicaid program, please use one of the following options:

- Call the Molina Healthcare Alert line at **(866) 606-3889**
- Complete a report form online at **MolinaHealthcare.alertline.com**

Addresses for reporting:

Medicaid Provider Fraud
Medicaid Fraud and Patient Abuse Unit
1221 N Street, Suite 500, Lincoln, NE 68509-8920
Phone: (402) 471-3549 or toll-free at (800) 727-6432
Email: ago.medicaid.fraud@nebraska.gov

Medicaid Provider Self-Disclosure
Nebraska Medicaid Program Integrity
PO Box 95026, Lincoln, NE 68509
Phone: (877) 255-3092
Email: DHHS.MedicaidProgramIntegrity@nebraska.gov
Online: dhhs.ne.gov/Pages/Program-Integrity.aspx

Medicaid Client Fraud: Special Investigation Unit
Phone: (402) 595-3789
Email: Investigations.SIU@dhhs.ne.gov

Grievance and appeals

Grievances

Grievances are complaints given to Molina by you or someone you choose to help you.

Grievances can be about the way your health care services were handled by your provider or Molina. Some examples include:

- Rudeness from a provider or employee
- Unacceptable quality in your care or how you were treated
- Failure to respect your member rights
- Unreasonable amount of time to authorize decisions
- Any other problems you have getting health care

How to file a grievance

You can file a grievance with Molina at any time. We have an Appeal and Grievance Form you can use to file your grievance and provide the information we need. The Appeal and Grievance Form is available at the end of this handbook, on the Molina website, and online inside your member portal.

You can choose someone to help you file a grievance. Use the Appointment of Representative (AOR) Form to give written consent to allow someone to file a grievance on your behalf. The AOR form is available at the end of this handbook, on the Molina website, and online inside your member portal.

To file a grievance, you can:

- **Call Member Services** at (844) 782-2018 (TTY: 711)
- **Mail**:
  Molina Healthcare of Nebraska, Inc.
  Appeals & Grievances
  PO Box 182273, Chattanooga, TN 37422
- **Fax** it to: (833) 635-2044
- **Email**: MolinaHC.NE.AnG@MolinaHealthcare.com

What to expect when you file a grievance

Once you have submitted your grievance, Molina will let you know we received your grievance and are working on it within ten (10) calendar days. Molina will resolve the grievance as quickly as possible, but no more than ninety (90) calendar days from when we got your grievance. Molina will let you know the outcome to your grievance in writing.

Appeals

You can request an appeal for us to review a decision that we made about a service that was denied, reduced, or limited. Some examples of appeals would be:

- Denial in whole or part of a requested service
- A service that was previously approved has stopped

A denial is when we do not approve or pay for a service that either you or your doctor asked for. When we deny a service, we will send you a letter telling you why we denied the requested service.

This letter is the official notice of our decision and is called an **Adverse Benefit Determination**. It will tell you about your rights and information about how to request an appeal.

How to file an appeal

You must send your appeal within 60 calendar days of the date of our denial letter.

You can appeal the decision, or you can also appoint someone else to file an appeal for you. This is called an authorized representative. An authorized representative can be your provider, a relative, friend, or even an attorney. If someone is going to file an appeal for you, they must have your written consent. If you need help filing your appeal, you can call Member Services and we will help you complete the steps for filing an appeal. You can appeal our decision in writing or over the phone by contacting Member Services at **(844) 782-2018 (TTY: 711)**. You can also file an appeal by:

- **Mail**:
  Molina Healthcare of Nebraska, Inc.
  Attn: Appeals & Grievances
  PO Box 182273, Chattanooga, TN 37422
- **Fax**: **(833) 635-2044**
- **Email**: **MolinaHC.NE.AnG@MolinaHealthcare.com**

An appeal form and authorized representative form can be found in your denial letter and online at **MolinaHealthcare.com**. Molina offers only one (1) level of appeal for members.

What to expect when you file an appeal

Once you have submitted your appeal, Molina will let you know we received your appeal and are working on it within ten (10) calendar days. Molina will resolve the appeal as quickly as possible, but no more than thirty (30) calendar days from when we got your appeal. Molina will let you know the outcome to your appeal in writing.

Expedited (fast) appeals

If you feel that waiting 30 calendar days will put your health in danger, you may ask for an expedited (fast) appeal. You may need an expedited decision if not getting the treatment will cause:

- Risk of serious health problems or death
- Any serious problems with your heart, brain, lungs, or other body parts
- Any serious problems with your mental health

When you submit your appeal by phone, mail, or fax, let us know if you think you need an expedited appeal. We will send your request for review. If your appeal needs an expedited review, a decision will be made as quickly as your health requires and within 72 hours. You will have less time to give us information to support your appeal during an expedited appeal. Because of this, make sure to include any information to support your appeal when you send it to us. If your appeal does not meet the conditions for an expedited review, we will let you know.

If you think you need an expedited appeal decision, contact our Member Services Department at **844-782-2018 (TTY: 711)**, from 8 a.m. to 6 p.m. CT, Monday through Friday.

State Fair Hearings

If you do not agree with our appeal decision, or if our appeal decision was not made within the required time frames of 30 days (for standard appeals) or 72 hours (for expedited appeals), you have another option. You can file a State Fair Hearing with DHHS.

You must have completed the appeal process with us before you can file a State Fair Hearing. You or an authorized representative who has your written consent can file a State Fair Hearing on your behalf. This must be done within 120 days from the date of the letter sent with our decision about your appeal.

You can file a State Fair Hearing in writing at this address:

MLTC Appeal Coordinator, PO Box 94967, Lincoln, NE 68509-4967

Your State Fair Hearing request must:

- Be in writing and specify the reason for your request
- Include your name, address, and phone number
- Indicate the date of service or the type of service that was denied
- Include the name of your provider

A State Fair Hearing is a legal proceeding. Those who attend the hearing include:

- You
- Your approved representative (if you've chosen one)
- A Molina representative
- A hearing officer from MLTC

You can also request to have your State Fair Hearing over the phone. At the State Fair Hearing, we will tell you why we made our decision. You or your approved representative will tell the hearing officer why you think we made the wrong decision. The hearing officer will decide whether our decision was right or wrong. The hearing officer will notify you of their decision in writing.

Continuation of benefits during an appeal or State Fair Hearing

We will continue offering you your benefits when an appeal or State Fair Hearing is pending if all the following are met:

- You must file the request for an appeal within 60 calendar days from the date on the notice from Molina denying your service request
- The appeal or State Fair Hearing request is related to the termination, suspension, or reduction of services that were previously authorized for you
- The services were requested by an authorized Molina doctor
- The period covered by the original authorization has not ended
- The request for continuation of benefits is filed:
  - Within 10 calendar days from the date we mailed the **Adverse Benefit Determination or**
  - By the effective date of the notice

If the above are met, your benefits must be continued until one of the following occurs:

- You ask to stop the appeal or State Fair Hearing
- You do not request a State Fair Hearing within 10 days from the date on Molina's letter notifying you of our decision
- The authorization for services expires or prior authorization limits are met
- The State Fair Hearing decision is to deny your request

Remember: If you keep getting a service during the appeal process or State Fair Hearing and you lose the appeal, you may be responsible for the cost of the services you received.

Notice of Privacy Practices

MOLINA HEALTHCARE OF NEBRASKA, 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 Nebraska, Inc. ("Molina", "we" or "our") uses and shares protected health information about you to provide your health benefits as a Molina member. We use and share your information to carry out treatment, payment, and health care 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 and to follow the terms of this Notice. The effective date of this Notice is October 1, 2023.

PHI stands for these words, protected health information. PHI means health information that includes your name, Member number, or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

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

For Treatment

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment

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

For Health Care Operations

Molina 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.

Health care operations involve many daily business needs. It includes but is 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 detection and prosecution 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 use or share your PHI without getting written authorization (approval) from you?

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

Required by law

We 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 (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

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.

Health Care 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.

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

Your 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. An example would be to protect the President.

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

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

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

Molina needs your written approval to use or share your PHI for a purpose other than those listed in this Notice. Molina needs your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. 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 us not to share your PHI to carry out treatment, payment, or health care operations. You may also ask us not to share your PHI with family, friends, or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request.
- **Request Confidential Communications of PHI**
  You may ask Molina 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 make your request in writing. You may use Molina's 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 member. You will need to make your request in writing. You may use Molina's 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. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.
- **Amend Your PHI**
  You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use Molina's 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 we 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 health care operations
  - To persons about their own PHI
  - Sharing done with your authorization
  - An incident to a use or disclosure otherwise permitted or required under applicable law
  - PHI released in the interest of national security or for intelligence purposes
  - As part of a limited data set in accordance with applicable law

Get a Separate Copy of this Notice

We will charge a reasonable fee for each list if you ask for this list more than once in a 12- month period. You will need to make your request in writing. You may use Molina's form to make your request.

You may make any of the requests listed above or may get a paper copy of this Notice. Please call our Member Services at the toll-free number on your Molina ID card.

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

You may complain to Molina 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 and benefits will not change in any way.

You may file a complaint with us at:

- Call our Member Services at the toll-free number on your ID card.
- Write to Member Services, 200 Oceangate, Suite 100, Long Beach, CA 90802.

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

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

Phone: **(800) 368-1019, TTY: (800) 537-7697**, Fax: **(202) 619-3818**

We will not hold anything against you. Your action would not change your care in any way.

What are the duties of Molina?

Molina is required to:

- Keep your PHI private
- Give you written information such as this on our duties and privacy practices about your PHI
- Provide you with a notice in the event of any breach of your unsecured PHI
- Not use or disclose your genetic information for underwriting purposes
- Follow the terms of this Notice

This Notice is Subject to Change

Molina 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, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Non-discrimination notice

Molina Healthcare of Nebraska complies with applicable Federal civil rights laws that relate to health care programs and does not discriminate based on race, color, national origin, disability, age, sex, religion, or marital status.

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

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

If you need these services, contact Molina of Nebraska Member Services at **(844) 782-2018** or **(TTY/TDD: 711)**.

If you think that Molina has discriminated based on race, color, national origin, disability, age, sex, religion, or marital status, you can file a grievance. You can file a grievance in person, by mail, fax, email, online, or phone. If you need help writing your grievance, we will help you. Call our Civil Rights Coordinator at **(866) 606-3889 (TTY/TDD: 711)** or submit your grievance to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

Fax: **(833) 598-3002**

Email: **Civil.Rights@MolinaHealthcare.com**

Website: **MolinaHealthcare.Alertline.com**

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

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

Phone: **(800) 368-1019**

TTY/TDD: **(800) 537-7697**

Forms

1. **DHHS Appeal Form**: Use this form to request a State Fair Hearing.
2. **Authorization for the use and disclosure of protected health information (PHI)**: Use this form to give Molina permission to disclose your PHI to approved individuals and/or organizations.
3. **Grievance/Appeal Form**: Use this form to file a grievance or appeal.
4. **Authorized Representative Designation Form**: Use this form to designate an authorized representative.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Legal and Regulatory Services

NOTICE AND PETITION FOR FAIR HEARING

FOR LEGAL SERVICES USE ONLY

Local Office Worker _____

Local Office Town _____

Case Number/Social Security Number _____

Received in Local Office _____
(Date)

To the Director of Health and Human Services, Lincoln, Nebraska.

SEE INSTRUCTIONS ON BACK

I hereby appeal the (1) _____ for
(Action or Inaction)

(2) _____ for
(Name) (Address)

(3) _____ (4) I, _____
(Type of Aid) (Name)

the undersigned, believe a State employee of Health and Human Services or another official has:
Check one: ☐ erred, effective (5) _____ (date).
☐ failed to act with reasonable promptness.

(6) The reasons for this belief are as follows:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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TSU 03/2008

DA-6-S Rev. 3/08 (09052)
(Previous version 4/07 should be used)

I understand that I may continue to receive my current level of assistance pending my appeal decision, if my appeal is filed within ten (10) day of my notice of adverse action. I also understand that the benefits must be repaid from future assistance or reimbursed to the Department of Health and Human Services directly, if the appeal decision is not in my favor.

If you do not wish to continue your assistance pending the appeal decision, please indicate in the box.
☐ Having checked this box, I understand that my assistance will be discontinued or reduced until an appeal decision is made.
Note: If the box is not checked, current level of benefits will continue.

Therefore, I appeal to the Director of Health and Human Services for review of this matter, and a hearing, if necessary, in accordance with the law.

_____
(Signature of Applicant) (Date)

_____
(Street Address or P.O. Box Number)

_____
(City, State, Zip) (Telephone Number)

INSTRUCTIONS FOR COMPLETING REQUEST FOR FAIR HEARING

HEADING

Local Office –Enter the name of the local office of the applicant's (recipient's) residence and the case number in the appropriate places. Enter the date the Notice and Petition is received in the local office.

BODY OF FORM

1. Action or Inaction–Enter one of the following phrases: "Approving the application," "Rejecting the application," "Increasing the payment," "Decreasing the payment," "Discontinuing payment," "Failing to act with reasonable promptness."

2. Name and Address– Enter the name and address of the applicant (recipient).

3. Type of Aid–Enter the type of assistance: Aged to the Aged, Blind or Disabled (AABD), Aid to Dependent Children (ADC), Children and Family Services (CFS), Medical Assistance (MA), Food Stamp Program (FSP), Commodity Distribution (CD), Medically Handicapped Children (MHC), Emergency Assistance (EA), Low Income Energy Assistance Program (LIEAP), Refugee Resettlement Program (RRP).

4. Name – Give the name of the person appealing the action, (who may be the applicant, recipient, guardian, conservator, applicant's representative, or a taxpayer.)

5. Date–Enter the effective date (first of month for which action is effective) of the decision of the local office or other official from which the petitioner is appealing. If "failure to act with reasonable promptness" is the reason for the appeal, check (□) appropriate box.

6. The Reason for Appeal –Write the specific reason for appealing from the decision of the local office or other official.

SIGNATURES AND DATES

The person making the appeal must sign the form, entering the date and his address.

PROCEDURES FOR A FAIR HEARING

1. This form should be completed in triplicate. Request for a fair hearing may also be made in the form of a simple letter or written request to the Legal Services - Hearing Section, P.O. Box 98914, Lincoln, Nebraska 68509-8914. The request must be made in writing.

2. If request is made on this Form (DA-6,) one copy is sent to the Nebraska Department of Health and Human Services, Legal Services- Hearing Section, one copy to the appropriate local office, and the third copy is retained by the person appealing.

3. The person appealing is notified by the Director or his/her representative of the date and place of hearing.

4. The hearing is held by the Director or his/her representative. Both the person appealing and the State may ask witnesses to appear.

5. A complete report of this hearing is made to the Director of the Nebraska Department of Health and Human Services by the Hearing Officer.

6. A written decision by the Director of the Nebraska Department of Health and Human Services is transmitted to both the person appealing and the appropriate local office.

Authorization for the Use and Disclosure of Protected Health Information

Name of Member: _____ Member ID#: _____

Member Address: _____ Date of Birth: _____

City/State/Zip: _____ Telephone #: _____

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.

1. Persons or organizations authorized to use or disclose the protected health information:

_____

_____

_____

2. Name(s) and address(es) of persons or organizations authorized to receive or use the protected health information: (please print)

_____

_____

_____

3. Specific description of the protected health information that may be used or disclosed:

_____

_____

_____

4. **Release Requiring Specific Approval:** I know my records may contain PHI about testing, diagnosis or treatment for HIV/AIDS, for any other Sexually Transmitted Diseases (STDs), for Alcohol and Drug Abuse, for Chemical Dependency, and/or for Mental Health. I will allow Molina Healthcare to disclose and/or re-disclose any and all such information, except for the information I initial below.

   I don't want my health care information about testing, diagnosis or treatment for the following shared:

   ___ HIV/AIDS; ___ Other STDs; ___ Alcohol & Drug Abuse/Chemical Dependency; ___ Mental Health

5. The protected health information will be used or disclosed for:

_____

_____

_____

6. I understand the following:

   a) I may revoke this authorization at any time. I can do this by telling Molina Healthcare in writing or verbally. This right does not apply to actions already taken by Molina Healthcare because of this authorization.

Rev. 6_25_21

b) I know this authorization is voluntary and I may refuse to sign. If I refuse to sign this, it will not affect my
Treatment
Payment or
Enrollment or eligibility for my benefits

c) I know the PHI I authorize a person or entity to receive may be re-disclosed. I know that state and federal law may no longer protect this PHI. Please see "Notice of Recipients of Alcohol and Drug Abuse Information" below.

d) I have a right to receive a copy of this authorization.

7. This authorization expires 90 days from the date of your signature unless otherwise specified below.

This authorization expires [on /upon] _____

Signature of Member or Member's Personal Representative	Date

Personal Representative's Name, if applicable (please print): _____

Relationship to Member: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney *

☐ Other Please Describe: _____

Description of Personal Representative's authority to act for the member (please print):

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney for Healthcare Decisions.

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare.

NOTICE TO RECIPIENTS OF ALCOHOL OR DRUG ABUSE INFORMATION
This information has been disclosed to you from records protected by the Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Rev. 6_25_21

Member Appeal/Grievance Form

Please see information on "How to File an Appeal or Grievance" on the second page of this form.

Part I. Member Information

Member First Name: _____ Member Last Name: _____

Member ID #: _____ Member DOB: _____

Member Address: _____

City, State, Zip Code: _____

Member Phone #: _____

Part II. Appeal or Grievance Information

Tell us about your appeal or grievance. Please give us all the information you have. If you are filing an appeal, you have 60 days from the day you receive the letter about an adverse decision. Add another sheet of paper to this form if more space is needed.

_____

_____

_____

_____

Part III. Relationship to Member

*Documents showing Legal Guardianship or Power of Attorney must be provided to us.

☐ Self ☐ Parent ☐ Other, please specify:

☐ Guardian* ☐ Power of Attorney* _____

Member Signature: _____ Today's Date: _____

1— NE – Appeal/Grievance Form – Member - 2023

How to File an Appeal or Grievance:

1. This form gives us the information needed to help you with your appeal or grievance. Fill out each part of this form. Describe the issue(s) in as much detail as possible. Include your signature.

2. Please write clearly and in **print**.

3. If you have information you want to include with this form, attach copies (Do Not Send Originals). Some examples of information to include could be a copy of a bill you received from a doctor or medical records.

4. You may present information in person. To do this, call our Member Services Help Line at 1-844-782-2018.

5. We can help you write your request, and we can help you in the language you speak. If you need services for the hard of hearing, you may call our TTY/TTD phone number at 711.

6. If you are a legal guardian or Power of Attorney filing an appeal or grievance for our member, you must send us the documents showing this.

7. If you are over the age of 18, you can have someone else file your appeal or grievance for you with your written consent. This is called an Authorized Representative. Your Authorized Representative can be your provider, a relative, friend, and even an attorney.

    - To give your written consent, use the Appointment of Representative (AOR) Form enclosed.

8. You or someone you have chosen to act on your behalf, can review your appeal file before or during the appeal process. Your appeal file includes all your medical records and any other documents related to your case. You can request this by calling our Member Services Help Line at 1-844-782-2018.

9. Return this completed form and any extra information related to your appeal or grievance to:

    Molina Healthcare of Nebraska
    Appeal and Grievance Unit
    P.O Box 182273
    Chattanooga, TN 37422
    Fax: 1-833-635-2044

10. You may also submit your appeal or grievance via your My Molina Portal.

11. We will let you know in writing that we received your appeal or grievance within 10 calendar days. If you filed an expedited (fast) appeal, you would receive a notice in writing within 72 hours.

Thank you for using the Molina Healthcare of Nebraska Appeal and Grievance process.

Member Appointment of Representative (AOR) Form

Part I. Member Information

Member First Name: _____ Member Last Name: _____

Member ID #: _____ Member DOB: _____

Part II. Authorized Representative Information

First Name: _____ Last Name: _____

Phone #: _____ Relationship to Member: _____

Address: _____

City, State, Zip Code: _____

Part III. Appointment of Representative

I, _____, agree to name
(Member Name)

_____ to be my authorized representative
(Representative Name)

during my appeal or grievance about _____.
(Specific Issue)

☐ I understand that this is my written consent for the mentioned representative to act on my behalf during the appeal or grievance and that Personal Health Information related to my appeal or grievance may be given to my authorized representative.

☐ I understand that my authorized representative can make requests or provide Molina with information related to my appeal or grievance, which may include Personal Health Information.

Member Signature: _____ Today's Date: _____

Representative Signature: _____ Today's Date: _____

Appointment of Representative (AOR) Form

Member Name _____ **Molina Member ID Number** _____

APPOINTMENT OF REPRESENTATIVE

I agree to name _____(Name and address) to be my representative with a grievance or an appeal for _____(specific issue).

I approve this person to make or give any request or notice; present or evidence; to obtain information, including, without limitation, the release of past, present or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in relation with my pending grievance/appeal.

SIGNATURE (member) _____ **ADDRESS** _____

TELEPHONE NUMBER (AREA CODE) _____ **DATE** _____

ACCEPTANCE OF APPOINTMENT

I, _____, hereby agree to the above appointment. I certify that I have not been suspected or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.

I am a/an _____
(Attorney, union representative, relative, etc.)

SIGNATURE (Representative) _____ **ADDRESS** _____

TELEPHONE NUMBER (with Area Code) _____ **DATE** _____


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