MEMBER RIGHTS & RESPONSIBILITIES

You have the right to:

- Be treated with respect and recognition of your dignity by everyone who works with Molina Healthcare.
- Receive information about Molina Healthcare, our providers, our doctors, our services and member's right's and responsibilities.
- Choose your primary care physician (PCP) from Molina Healthcare's network.
- Be informed about your health. If you are ill, you have the right to be told about treatment options regardless of cost or benefit coverage. You have the right to have all questions about your health answered.
- Help make decisions about your health care. You have the right to refuse medical treatment.
- Privacy. Molina Healthcare keeps your medical records private in accordance with State and Federal laws.
- See your medical record. You also have the right to ask for corrections to your medical record and receive a copy of it in compliance with State and Federal requirements.
- Complain about Molina Healthcare or your care by calling, faxing, e-mailing or writing to Molina Healthcare's Member Services Department.
- Appeal Molina Healthcare's decisions. You have the right to have someone speak for you during the grievance.
- Disenroll from Molina Healthcare.
- Ask for a second opinion about your health condition.
- Ask for an external independent review of experimental or investigational therapies.
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury.
- Receive interpreter services at no cost to help you talk with your doctor or Molina Healthcare if you prefer to speak a language other than English.
- Not be asked to bring a friend or family member with you to act as your interpreter.
- Receive information about Molina Healthcare, your providers, or your health in your preferred language. You also have the right to request and receive materials in other formats such as larger size print and Braille. You have the right to request information in printed form translated into your preferred language.
- Receive a copy of Molina Healthcare's drug formulary on request.
- Access minor consent services.
- You have the freedom to exercise these rights without negatively affecting how you are treated by Molina Healthcare, its providers or the Managed Risk Medical Insurance Board.
- Make recommendations regarding the organization's member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish or seek revenge.
- File a grievance or complaint if they believe your linguistic needs were not met by the plan.

You have the responsibility to:

- Be familiar with and ask questions about

your health benefits. If you have a question about your benefits, you may call Molina Healthcare's Member Services Department at **1 (888) 665-4621.**

- Provide information to your doctor or Molina Healthcare that is needed to care for you. If you are pregnant, be honest about your medical history and lifestyle because it may affect your unborn baby's health.
- Report any changes in your health.
- Be active in decisions about your health care.
- Follow the care plans and instructions for care that you have agreed on with your doctor(s) and ask questions if you do not understand explanations and instructions.
- Build and keep a strong patient-doctor relationship.
- Cooperate with your doctor and staff. This includes being on time for your visits or calling your doctor if you need to cancel or reschedule an appointment.
- Present your Molina Healthcare and State card when receiving medical care and report any fraud or wrongdoing to Molina Healthcare or the proper authorities.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Inform the Member Services Department of any change of address or any changes to entitlement that could affect continuing eligibility.

MOLINA HEALTHCARE'S OMBUDSMAN PROGRAM

If you are not receiving the help you need, you may also call the Ombudsman. You can call Molina Healthcare's Ombudsman toll-free at **1 (877) 665-4627**. You may also write a letter to the Ombudsman. Send your letter to the following address:

Molina Healthcare
Ombudsman Program
200 Oceangate, Suite 100
Long Beach, CA 90802

A person from the Ombudsman Program will talk with you and give you the help you need. Molina Healthcare wants to give you the best customer service possible. This program does not take the place of the grievance process. Any problem with a Plan Provider or Molina Healthcare will be handled as a grievance. The Ombudsman Program can help you get the answer to a question or concern that you may not have received from Member Services.

GRIEVANCES AND APPEALS PROCESS

What is the Grievance Process?

If you are having any problems with a Plan Provider or your health plan, give us a chance to help. You can call any of the following toll-free numbers for help:

- Call Molina Healthcare Member Services at 1 (888) 665-4621, Monday through Friday, 7:00 a.m. – 7:00 p.m. If you are deaf or hard of hearing, please call our

- dedicated TTY/TDD line at 1 (800) 479-3310 or contact us through the California Relay Service by dialing 711.
- Call the California State Department of Managed Health Care (DMHC) at 1 (888) HMO-2219.

Member Services can assist in working out any issues. If you ever have a question or concern, call our Member Service Department. Our Member Services Representative will make every effort to assist you.

Grievances

Please call Molina Healthcare at **1 (888) 665-4621**. If you are deaf or hard of hearing, please call our dedicated TTY/TDD line at 1 (800) 479-3310. You may also send us your problem or complaint in writing. Our address is:

Molina Healthcare
Member Services Department-
Grievance and Appeals Unit
200 Oceangate, Suite 100
Long Beach, California 90802

You may also send us your problem or complaint online. The website address is www.molinahealthcare.com or you may download the grievance form from the following internet address: www.molinahealthcare.com/mhc/member/accessingcare/membergrievance-mhp.htm

You may not always be happy with the care and services provided by your doctor. We want to know about your problems and complaints. You may not be happy that your language needs are not met. You may file a grievance in person, in writing, by e-mail, fax, TTY/TDD or telephone. We will send you a letter within five (5) calendar days from the date of receipt of the grievance telling you we got your grievance. We will send you a letter with our decision on your issue within thirty (30) calendar days from the date of receipt of the grievance.

If you are not happy with our response to your grievance you may be able to file an appeal with Molina Healthcare if it is received and can be processed within (30) calendar days of the initial receipt of the grievance response. You may file an appeal in person, in writing, by e-mail, fax, TTY/TDD or telephone. We will send you a letter acknowledging receipt of your appeal within five (5) calendar days. All levels of Molina Healthcare's grievances and appeal procedures will be completed in thirty (30) calendar days.

You should first attempt to resolve disputes with the Plan according to its established policies and procedures. If you are dissatisfied with the resolution of your grievance you can appeal to the California Managed Risk Medical Insurance Board (MRMIB).

The appeal must be submitted to MRMIB in writing within sixty (60) calendar days following the Plan's decision. The appeal must include the following:

- A copy of any decision being appealed or a written statement of the action or failure to act being appealed;
- A statement specifically describing the issue you are disputing;
- A statement of the resolution you are requesting; and

- Any other relevant information you would like to include.

Appeals that do not include the above information will be returned. You may resubmit the complete appeal within the sixty (60) calendar days from the Plan's denial or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

Mail your appeal to the following address:

Executive Director
Benefits Appeal
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

Expedited Review

If your grievance involves an imminent and serious threat to your health, Molina Healthcare will quickly review your grievance. Examples of imminent and serious threats include, but are not limited to, severe pain, potential loss of life, limb, or major bodily function. Molina Healthcare will issue a formal verbal and written response no later than three (3) days after your initial contact with us.

When you contact Molina Healthcare, you will be immediately informed of your right to contact the Department of Managed Health Care. You do not have to file a grievance with Molina Healthcare before you contact the Department of Managed Health Care.

Additional Resources

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-665-4621 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

If your case is determined by the Department of Managed Health Care to involve an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life,

limb, or major bodily function, or if for any other reason the Department determines that an earlier review is warranted, you will not be required to participate in the Plan's grievance process for 30 days before submitting your grievance to the Department for review.

If you believe that your (or your Dependent's) coverage was terminated or not renewed because of health status or requirements for benefits, you may request a review of the termination by the Director of the California Department of Managed Health Care, at the telephone numbers and Internet websites listed above, pursuant to Section 1365(b) of the California Health and Safety Code.

Independent Medical Review

You may request an independent medical review ("IMR") of a disputed healthcare service from the Department of Managed Health Care (DMHC) if you believe that healthcare services have been improperly denied, modified, or delayed by Molina Healthcare or one of its contracted providers. A "disputed healthcare service" is any healthcare service eligible for coverage and payment that has been denied, modified, or delayed by Molina Healthcare or one of its contracted providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. Molina Healthcare will provide you with an IMR application form with any disposition letter that denies, modifies, or delays healthcare services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Molina Healthcare regarding the disputed health care service.

Eligibility: Your application for an IMR will be reviewed by the DMHC to confirm that:

1. A. Your provider has recommended a healthcare service as medically necessary, or B. You have received urgent care or emergency services that a provider determined was medically necessary, or C. You have been seen by a Plan Provider for the diagnosis or treatment of the medical condition for which you seek medical review;
2. The disputed healthcare service has been denied, modified, or delayed by Molina Healthcare or one of its contracting providers, based in whole or in part on a decision that the healthcare service is not medically necessary: and
3. You have filed a grievance with Molina Healthcare or its contracting provider and the disputed decision is upheld or the grievance remains unresolved after 30 days. You are not required to wait for a response from Molina Healthcare for more than thirty (30) days.

   If your grievance requires **Expedited review** you may bring it immediately to the DMHC's attention. You are not required to wait for response from Molina Healthcare for more than three (3) days. The DMHC may waive the requirement that you follow Molina Healthcare's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will get a copy of the assessment made in your case. If the IMR determines the service is medically necessary, Molina Healthcare will provide the healthcare service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) days.

For more information regarding the IMR process, or to request an application form, please call Molina Healthcare at **1 (888) 665-4621**. If you are deaf or hard of hearing, call our dedicated TTY/TDD line at 1 (800) 479-3310.

Independent Medical Review for Denials of Experimental/ Investigational Therapies

You may also be entitled to an Independent Medical Review of our decision to deny coverage for treatment we have determined to be experimental or investigational.

- **The treatment must be for a life-threatening or seriously debilitating condition.**
- **We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage.**
- **You are not required to participate in the Plan's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/investigational therapy.**
- **The Independent Medical Review will be completed within 30 days of the Department of Managed Health Care's receipt of your application and supporting documentation. If your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.**

Health Plan Covered Benefits Matrix

This chart is intended to be used to help you compare coverage benefits and is a summary only. Please go to Benefit Descriptions starting on page 21 for a detailed description of covered benefits.

Service	Coverage	Copayment/ Visit
Deductibles (Money people (have to pay to get a service)	There are no deductibles in the plan.	$0
Lifetime Maximums	There are no lifetime maximums under the plan.	n/a
Professional Services (General medical care provided by a licensed medical person)	Shots (immunizations), periodic health exams (including all routine, diagnostic testing, Human Immunodeficiency Virus (HIV) testing and laboratory services appropriate for such examinations) vision exams (with primary care physician), hearing exams.	$0
	Prenatal and postpartum care.	$0
	Appropriate routine diagnostic testing and lab services. Physician visits in a hospital.	$0
	Office visits, allergy tests and treatments.	$0
Outpatient Services (Medical care services outside of the hospital)	Maternity care, diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility, use of operating room, treatment room, ancillary services, and required drugs, radiation therapy, chemotherapy, dialysis, x-ray and laboratory services.	$0
Physical, Occupational, and Speech Therapy	Provided in a medical office or other appropriate outpatient setting	$0
Hospitalization Services	Room and board, maternity and newborn care, use of operating rooms and related ancillary charges, medically needed drugs, x-rays and lab services, chemotherapy, and various diagnostic services.	$0

Benefits

Emergency Health Services	Emergency Room and Urgent Care Center services for an illness or injury requiring immediate diagnosis and treatment.	$0
Nutrition Services	Includes nutrition assessment.	$0
Medical Transportation/ Ambulance Services	Use of an ambulance in an emergency situation, or when your PCP requests a transfer from one facility to another.	$0
Prescription Drug Coverage (Your doctor may be able to get approval for a drug not on the Molina Healthcare “drug list”)	FDA approved contraceptive drugs and devices.	$0
	• FDA approved drugs prescribed by a doctor that are listed in our drug list or “drug formulary”. • Drugs approved by our medical director.	$0
Durable Medical Equipment	Equipment designed to serve a repeated medical purpose.	$0
Mental Health Services	**Inpatient Mental Health Care Services** Mental health care in a participating hospital when ordered and performed by participating mental health professional for the treatment of a mental health condition. Basic Mental Health Care Services · Diagnosis and treatment of a mental health condition. · Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED). · 30 days per benefit year. · Molina Healthcare, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: -2 days of residential treatment, -3 days of day care treatment, or -4 outpatient visits. Severe Mental Illness (SMI) · Inpatient mental health care services for the treatment of severe mental illnesses. · Unlimited days. Serious Emotional Disturbance (SED) Services · Inpatient mental health care services for the treatment for SED conditions. · Unlimited days.	$0

Mental Health Services	**Outpatient Mental Health Care Services** Mental health care when ordered and performed by a participating mental health professional. Basic Mental Health Care Services · Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED). · This includes, but is not limited to, the treatment of members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. · Family members may be involved in the treatment when medically necessary for the health and recovery of the member. · 20 visits per benefit year. Additional days may be authorized by Molina Healthcare. Severe Mental Illness (SMI) · Outpatient mental health care visits for the treatment of severe mental illnesses. · Unlimited visits. Serious Emotional Disturbance (SED) Services · Outpatient mental health care visits for the treatment for SED condition. · Unlimited visits.	$0
Chemical Dependency Services	Inpatient detoxification	$0
	Outpatient crisis intervention and treatment, up to 20 visits per year.	$0
Home Health Services	Health services provided by health care professionals. Custodial care is not covered.	$0
Hospice Care	When elected by a terminally ill member	$0
Orthotics and Prosthetics	Coverage for the initial and replacement of prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy. Also includes therapeutic footwear for diabetics and prosthetic devices to restore and achieve symmetry incident to mastectomy.	$0
Skilled Nursing Care	When medically necessary. Qualified licensed skilled nursing facility. Benefit limited to 100 days per Benefit Year.	$0
Blood and blood products	Include the processing, storage, and administration of blood and blood products in an inpatient or outpatient setting and the collection and storage of autologous blood when Medically Necessary.	$0
Organ Transplants	Organ and tissue transplants are covered when medically necessary.	$0
Reconstructive Surgery	Medically necessary reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease are covered when performed to improve function or create a normal appearance, to the extent possible.	$0
Diabetic Care	Prescriptions as described in the Prescription drug and medication section.	$0
Cancer Clinical Trials	Prescriptions as described in the Prescription drug and medication section.	$0