CA H5810-016

2023 Member Handbook

Molina Medicare Complete Care Plus (HMO D-SNP) a Medicare Medi-Cal Plan

California H5810-016

Serving the following counties: Los Angeles, Riverside (partial), San Bernardino (partial), and San Diego

Effective January 1 through December 31, 2023

MOLINA® HEALTHCARE

Molina Medicare Complete Care Plus (HMO D-SNP) a Medicare Medi-Cal Plan *Member Handbook*

01/01/2023 – 12/31/2023

Your Health and Drug Coverage under Molina Complete Care Plus (HMO D-SNP) a Medicare Medi-Cal Plan

Member Handbook Introduction

This *Member Handbook, otherwise known as the Evidence of Coverage,* tells you about your coverage under Molina Medicare Complete Care Plus through 12/31/2023. It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Keep it in a safe place.

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Molina Medicare Complete Care Plus (HMO D-SNP).

ATTENTION: If you speak: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Tagalog, Vietnamese, language assistance services, free of charge, are available to you. Call (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time. The call is free

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 665-4627 (TTY: 711).

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 (855) 665-4627（TTY：711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (855) 665-4627 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (855) 665-4627 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (855) 665-4627 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (855) 665-4627 (телетайп: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-665-4627 (رقم هاتف الصم والبكم: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-665-4627 (TTY: 711) تماس بگیرید.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (855) 665-4627 (TTY (հեռատիպ)՝ 711):

ប្រយ័ត្ន៖ បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បីរអ្នក។ ចូរទូរស័ព្ទ (855) 665-4627 (TTY: 711)។

You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request so you do not need to make separate requests each time we send you information. To get this document in a language other than English, please contact the State at (800) 541-5555, TTY: 711, Monday – Friday, 8 a.m. to 5 p.m., local time to update your record with the preferred language. To get this document in an alternate format, please contact Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time. A representative can help you make or change a standing request. You can also contact your Case Manager for help with standing requests.

2023 Molina Medicare Complete Care Plus (HMO D-SNP)

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Disclaimers

- Molina Medicare Complete Care Plus (HMO D-SNP) is a Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment in Molina Medicare Complete Care Plus depends on contract renewal.
- You can get this document for free in non-English language(s) or other formats, such as large print, braille, or audio. Call (855) 665-4627, TTY: 711. The call is free.
- Coverage under Molina Medicare Complete Care Plus (HMO D-SNP) is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

- Limitations, copays, and restrictions may apply. For more information, call Molina Medicare Complete Care Plus Member Services or read the Molina Medicare Complete Care Plus Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Molina Medicare Complete Care Plus pay for your services.

  NONDISCRIMINATION NOTICE

  Molina Healthcare (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
  If you believe that Molina has discriminated on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with:
  Civil Rights Coordinator
  200 Oceangate Long Beach, CA 90802
  Phone: (866) 606-3889Monday – Friday, 8 a.m. to 8 p.m., local time
  TTY: 711Fax: (562) 499-0610
  Email: civil.rights@MolinaHealthcare.com
  You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.
  You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:
  Deputy Director, Office of Civil Rights
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  (800) 368-1019 (800) 537-7697 (202) 619-3818 OCRMail@hhs.gov
  www.hhs.gov/ocr
  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx
  If you believe that Molina has discriminated on the basis of race, color, national origin, disability, age, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:
  https://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, DC 20201
  1–800–868–1019 or 800–537–7697 (TDD)
  Complaint forms are available at:
  http://www.hhs.gov/ocr/office/file/index.html.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Molina Medicare Complete Care Plus (HMO D-SNP) a health plan that covers all of your Medicare services and coordinates all of your and Medi-Cal services. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Welcome to our plan

Our plan provides Medicare and Medi-Cal services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have Case Managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

At Molina Healthcare, we understand every member is different and has unique needs. That is why Molina Medicare Complete Care Plus (HMO D-SNP) combines your Medicare and Medi-Cal benefits into one plan, so you can have personalized assistance and peace of mind.

Molina Healthcare was founded over 35 years ago, to bring quality health care to more people – especially those who need it most. From the beginning, Molina Medicare Complete Care Plus (HMO D-SNP) has put the needs of our members first, and we continue to do this today.

Welcome to Molina Healthcare. Your extended family.

B. Information about Medicare and Medi-Cal

B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, and
- People with end-stage renal disease (kidney failure).

B2. Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of California approved our plan. You can get Medicare and Medi-Cal services through our plan as long as:

- We choose to offer the plan, **and**
- Medicare and the State of California allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medi-Cal services is not affected.

C. Advantages of our plan

You will now get all your covered Medicare and Medi-Cal services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We will help make your Medicare and Medi-Cal benefits work better together and work better for you. Some of the advantages include:

- You can work with **us** for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a Case Manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and Case Manager.
- Your care team and Case Manager work with you to make a care plan designed to meet your health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

New members to Molina Medicare Complete Care Plus*:* In most instances you will be enrolled in Molina Medicare Complete Care Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in Molina Medicare Complete Care Plus. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Molina Medicare Complete Care Plus. There will be no gap in your Medi-Cal coverage. Please call us at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time if you have any questions.

D. Our plan's service area

Our service area includes these counties in California:

- Los Angeles county
- San Diego county
- Riverside and San Bernardino counties with the exception of the following ZIP codes:

- 92225, 92226, 92239, 92275, 92382, 92385, 92386, 92391, 92397, 92398,92409, 93562, 93592, 92242, 92252, 92256, 92267, 92268, 92277, 92278, 92280, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92323, 92325, 92326, 92327, 92332, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92363, 92364, 92365, 92366, 92368, 92372

Only people who live in our service area can join our plan.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **and**
- Are age 21 and older at the time of enrollment, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- Are currently eligible for Medi-Cal and, **and**
- Are a United States citizen or are lawfully present in the United States.

Call Member Services for more information.

Please note: if you lose your eligibility but can reasonably be expected to regain eligibility within 6-month(s), then you are still eligible for membership in our plan (Chapter 4, Section A tells you about coverage and cost sharing during this period, which is called deemed continued eligibility).

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before our after your effective enrollment date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, LTSS, and behavioral health and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, if they are not in our network. We call this continuity of care. If they are not in our network, you can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.

- We determine an existing relationship by reviewing your available health information available or information you give us.
- We have 30 days to respond to your request. You can ask us to make a faster decision and we must respond in 15 days.
- You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can only make this request for services of Durable Medical Equipment (DME), transportation, or other ancillary services, not included under in our plan. You **cannot** make this request for providers of DME, transportation or other ancillary providers.

After the continuity of care period ends, you will need to use doctors and other providers in the Molina Medicare Complete Care Plus network that are affiliated with your primary care provider's medical group, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Our plan's PCPs are affiliated with IPAs and medical groups. When you choose your PCP, you are also choosing the affiliated IPAs or medical group. This means that your PCP will be referring you to specialists and services that are also affiliated with his or her IPA or medical group. An IPA or Medical Group is an association of PCPs and specialists created to provide coordinated healthcare services to you. Refer to **Chapter 3** of your *Member Handbook* for more information on getting care.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a Case Manager, or other health person that you choose.

A Case Manager is a person trained to help you manage the care you need. You get a Case Manager when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your Case Manager and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS needs.

Your care plan includes:

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They talk with you about services you need. They also tell you about services you may want to think about getting. Your care plan is based on your needs. Your care team works with you to update your care plan at least every year.

H. Monthly plan premium

Our plan has no monthly plan premium.

I. Your *Member Handbook*

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook*, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* at www.MolinaHealthcare.com/Medicare or download it.

The contract is in effect for the months you are enrolled in Molina Medicare Complete Care Plus between 01/01/2023 and 12/31/2023.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*.

J1. Your Plan ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services covered by our plan, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or Part D prescriptions. Here is a sample Member ID Card:

If your Member ID Card is damaged, lost, or stolen, call Member Services right away and at the number at the bottom of the page. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card. Keep this card in a safe place, in case you need them later. If you show your Medicare card instead

of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access the following services:

- Specialty mental health services that you may get from the county mental health plan (MHP)
- Medi-Cal Rx covered drugs

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

This Directory lists the Primary Care Doctors (PCPs), hospitals, and other health care providers that are available to you as a member of Molina Healthcare. You can also find the following information about Molina Healthcare doctors and other health care providers in your Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Hospital Privileges / Affiliations
- Medical Group

It is important that patients are able to see doctors easily, and that doctors' offices provide any help they need to get care. Physical accessibility information is listed for:

- Basic Access
- Limited Access

We also use the following accessibility indicator symbols in our Provider Directories to show the other areas of accessibility at a provider office:

- P = Parking
- EB = Exterior Building
- IB = Interior Building
- W = Waiting Room
- R = Restroom
- E = Exam Room
- T = Exam Table
- S = Wheelchair Weight Scale

You can also find out whether or not a provider (doctors, hospitals, specialists, or medical clinics) is accepting new patients in your Provider Directory or at the web address at the bottom of the page.

Definition of network providers

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.

Each year, we send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website (refer to the information at the bottom of the page).

J4. *The Explanation of Benefits*

When you use your Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Part D prescription drugs and the total amount we paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. **Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records.

Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you**.

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.
- Admission to a nursing home or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your Case Manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Member Services

CALL	(855) 665-4627 This call is free. 7 days a week, 8 a.m. to 8 p.m., local time Assistive technologies, including self-service and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday - Friday, 8 a.m. to 8 p.m., local time
FAX	**For Medical Services:** Fax: (310) 507-6186 **For Part D (Rx) Services:** Fax: (866) 290-1309
WRITE	**For Medical Services:** 200 Oceangate, Suite 100 Long Beach, CA 90802 **For Part D (Rx) Services:** 7050 Union Park Center, Suite 200 Midvale, UT 84047
WEBSITE	www.MolinaHealthcare.com/Medicare

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.
- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your health care

- You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to **Section F**).
- You can call us and explain your complaint at (855) 665-4627, TTY:711, 7 days a week, 8:00 a.m. to 8:00 p.m., local time.
- If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
- You can send a complaint about our plan to Medicare. You can use an online form at medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- You can make a complaint about our plan to the Ombuds Program by calling (855) 452-8609.
- To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.

- Coverage decisions about your Medicare covered drugs
  - A coverage decision about your Medicare drugs is a decision about:
    - your benefits and Medicare covered drugs, **or**
    - the amount we pay for your Medicare drugs.
  - Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Appeals about your Medicare drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your Medicare prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your Medicare drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your Medicare prescription drugs.
  - If your complaint is about a coverage decision about your Medicare prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- For more on making a complaint about your Medicare prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or Medicare drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.

B. Your Case Manager

The Molina Medicare Complete Care Plus Case Manager is your main contact. This person helps you manage all of your providers, services and makes sure you get what you need. You and/or your caregiver may request a change in the Case Manager assigned, as needed by calling the Case Manager or Member Services. Additionally, our staff may make changes to your Case Manager assignment based upon your needs (cultural / linguistic / physical / behavioral health) or location. Contact Member Services for more information.

CALL	(855) 665-4627 This call is free. 7 days a week, 8 a.m. to 8 p.m., local time Assistive technologies, including self-services and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday - Friday, 8 a.m. to 8 p.m., local time
WRITE	200 Oceangate, Suite 100 Long Beach, CA 90802
WEBSITE	www.MolinaHealthcare.com/Medicare

Contact your Case Manager to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- Questions about long-term services and supports (LTSS)

LTSS include Community-Based Adult Services (CBAS), and Nursing Facilities (NF).

Sometimes you can get help with your daily health care and living needs.

You might be able to get these services:

- Community-Based Adult Services (CBAS),
- Skilled nursing care,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Medical social services, **and**
- Home health care.

C. Nurse Advice Call Line

You can call Molina Healthcare's Nurse Advice Line 24 hours a day, 365 days a year. The service connects you to a qualified nurse who can give you health care advice in your language and help direct you to where you can get the care that is needed. Our Nurse Advice Line is available to provide services to all Molina Healthcare Members across the United States. The Nurse Advice Line is a URAC-accredited health call center. The URAC accreditation means that our nurse line has demonstrated a comprehensive commitment to quality care, improved processes and better patient outcomes. Our Nurse Advice line is also certified by NCQA in Health Information Products (HIP) for our 24/7/365 Health Information Line. NCQA is designed to comply with NCQA health information standards for applicable standards for health plans.

Nurse Advise Line will assess your safety, link you to emergency services, find a behavioral health provider and community resources, and refer you to a Molina Case Manager.

If you have an emergency that may cause harm or death to you or others, go to the nearest hospital emergency room OR call 911.

CALL	(888) 275-8750 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 Hours a day, 7 days a week

D. Behavioral Health Crisis Line

CALL	(888) 858-2150 This call is free. 24 hours a day, 7 days a week Molina offers 24/7 access to licensed behavioral health professionals to provide counseling for mental health and substance abuse related issues by calling the Member Services Line. Interpretation services are available for members who require that service. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Contact the Behavioral Health Crisis Line for help with:

- Questions about behavioral health and substance abuse services
- Questions about substance use disorder services

- A Behavioral Crisis can be caused by environmental factors such as:
  - Loss of job
  - Recent death of a family member or close friend
  - Diagnosed with a major illness
  - Divorce
  - Unexpected financial burdens
  - Alcoholism or addiction
  - Substance abuse or addiction
  - Psychiatric illness
  - Intimate Partner Violence (domestic abuse)

For questions about your county specialty mental health services, refer to page 27.

E. Health Insurance Counseling and Advocacy Program (HICAP)

The Health Insurance Counseling and Advocacy Program (HICAP) gives free health insurance counseling to people with Medicare. HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is not connected with any insurance company or health plan.

CALL	(800) 434-0222 Monday - Friday, 9 a.m. to 4 p.m., local time.
TTY	711 Monday - Friday, 9 a.m. to 4 p.m., local time
WRITE	Los Angeles County: Center for Health Care Rights 520 S. Lafayette Park Place, Suite 214 Los Angeles, CA 90057 Riverside and San Bernardino Counties: Inland Agency HICAP 9121 Haven Ave, Suite 120 Rancho Cucamonga, CA 91739 San Diego County: Elder Law & Advocacy 5151 Murphy Canyon Road, Suite 100 San Diego, CA 92123
WEBSITE	http://www.cahealthadvocates.org/HICAP/

Contact HICAP for help with:

- Questions about your our plan or Medicare.
- HICAP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

F. Quality Improvement Organization (QIO)

Our state has an organization called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our plan.

CALL	(877) 588-1123
TTY	(855) 887-6668 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	https://www.livantaqio.com/en/states/california

Contact Livanta for help with:

- Questions about your health care rights
- You can make a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, and review the information with you.

H. Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, foster care, pregnant women, and individuals with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed by state and federal government..

CALL	1-844-580-7272 Monday through Friday, 8:00 a.m. and 6:00 p.m.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	www.healthcareoptions.dhcs.ca.gov/

I. The Office of the Ombudsman

The Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Ombudsman can also help you with service or billing problems. The Office of the Ombudsman will not automatically take sides in a complaint. They consider all sides in an impartial and objective way. It their job to help develop fair solutions to health care access problems. Their services are free.

CALL	1-888-452-8609 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time
TTY	711 This call is free.
WRITE	California Department of Healthcare Services Office of the Ombudsman 1501 Capitol Mall MS-4412 PO Box 997413 Sacramento, Ca 95899-7413
EMAIL	MMCDOmbudsmanOffice@dhcs.ca.gov
WEBSITE	https://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx

J. County Social Services

If you need help with your In-Home Supportive Services (IHSS) benefits, contact your local County Social Services Department. The In-Home Supportive Services (IHSS) program can provide services so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities. To apply for IHSS, contact your local county IHSS Office.

Los Angeles County

CALL	(888) 822-9622 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time
TTY	711
WRITE	Los Angeles County Department of Public Social Services 2707 South Grand Avenue Los Angeles, CA 90007
WEBSITE	http://dpss.lacounty.gov/wps/portal/dpss/main/about-us/customer-service-center

Riverside County

CALL	(888) 960-4477 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time
TTY	711
WRITE	County of Riverside In-Home Supportive Services 12125 Day Street, S-101 Moreno Valley, CA 92557
WEBSITE	http://dpss.co.riverside.ca.us/adult-services-division/in-home-supportive-services

San Bernardino County

CALL	(877) 800-4544 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time
TTY	711
WRITE	County of San Bernardino In-Home Supportive Services 686 E. Mill Street, 2nd Floor San Bernardino, CA 92414-0640
WEBSITE	http://hss.sbcounty.gov/daas/IHSS/Default.aspx

San Diego County

CALL	San Diego County: (800) 510-2020 This call is free. Outside San Diego County: (800) 339-4661 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time.
TTY	711
WRITE	Health and Human Services Agency County of San Diego In-Home Supportive Services 1600 Pacific Highway, Room 206 San Diego, CA 92101
WEBSITE	http://www.sdcounty.ca.gov/hhsa/programs/ais/inhome_supportive_services/index.html

K. County Specialty Mental Health Plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet the medical necessity criteria.

Los Angeles County Department of Mental Health:

CALL	(800) 854-7771 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	(562) 651-2549 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Riverside University Health Systems Behavioral Health- Community Access and Referral, Evaluation, and Support Line (CARES):

CALL	(800) 706-7500 This call is free. Monday - Friday 8 a.m. - 5:30 p. m., local time. We have free interpreter services for people who do not speak English.
TTY	(800) 915-5512 This call is free. Monday - Friday 8 a.m. - 5:30 p.m., local time

San Bernardino - Department of Behavioral Health:

CALL	(888) 743-1478 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week

San Diego - Mental Health Services:

CALL	(888) 724-7240 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	(619) 641-6992 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Contact the county specialty mental health plan for help with:

- Questions about behavioral health services provide by the county - contact your county mental health department at the numbers listed above.

Please refer to **Chapter 3** for information about Mental Health Benefits.

L. California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. The DMHC Help Center can help you with appeals and complaints about Medi-Cal services.

CALL	1-888-466-2219 DMHC representatives are available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday.
TDD	1-877-688-9891 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Help Center California Department of Managed Health Care 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725
FAX	1-916-255-5241
WEBSITE	www.dmhc.ca.gov

M. Other resources

The Health Consumer Alliance Ombuds Program (HCA) offers FREE assistance to help people who are struggling to get or maintain health coverage and resolve problems with their health plans.
If you have problems with:

- Medi-Cal
- Medicare
- Your health plan
- Accessing medical services
- Appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- Medical billing
- IHSS (In-Home Supportive Services)

Health Consumer Alliance assists with complaints, appeals, and hearings. The phone number for the Health Consumer Alliance is 1-888-804-3536.

To report Elder Abuse please contact the California Department of Social Services - Adult Protective Services in your county:

CALL	(877) 477-3646 24 hours a day, 7 days a week Riverside County: (800) 491-7123 24 Hour Hotline San Bernardino County: (877) 565-2020 24 Hour Hotline San Diego County: (800) 339-4661 24 Hour Hotline
TTY	711 24 hours a day, 7 days a week
WRITE	Community & Senior Services 3333 Wilshire Blvd., Suite 400 Los Angeles, CA 90010 Riverside County: Department of Public Social Services Adult Services Division 4060 County Circle Drive Riverside, CA 92501 San Bernardino County: Human Services System 784 E. Hospitality Lane San Bernardino, CA 92415 San Diego County: Aging & Independence Services P.O. Box 23217 San Diego, CA 92193-321
WEBSITE	http://www.cdss.ca.gov/Portals/9/APS/County_APD_Contacts_pdf

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your Case Manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook.*

Table of Contents

A. Information about services and providers

Services are health care (such as doctor visits and medical treatment), long-term services and supports (LTSS), supplies, behavioral health services (including mental health and wellness), prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports (LTSS) are listed in the Benefits Chart in **Chapter 4** of your *Member Handbook*. Covered prescription and over-the-counter drugs are in **Chapter 5** of your Member Handbook.

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain long-term services and supports (LTSS).

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers Medicare services and covers or coordinates all Medi-Cal services. This includes behavioral health and long-term services and supports (LTSS).

Our plan will coordinate health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit.** This means we include in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary.** By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another provider**.** As a plan member, you must choose a network provider to be your PCP.
  - In most cases, our plan must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists.
  - Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is an association of PCPs and specialists created to provide coordinated health care services to you.
  - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information about this, refer to section D1 in this chapter).
- **You must get your care from network providers that are affiliated with your PCP's medical group***.* Usually, we won't cover care from a provider who doesn't work with our health plan and your PCP's medical group. This means that you will have to pay the provider in full for the services

furnished from providers outside of the network. Here are some cases when this rule does not apply:

- We cover emergency or urgently needed care from an out-of-network provider (for more information about this, refer to section H in the chapter.
- If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. In this situation, we cover the care as if you got it from a network provider or at no cost to you.
- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.
- When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of your Member Handbook. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your Case Manager will contact you to help you find providers in our network that are affiliated with your PCP's medical group. After 12 months, we no longer cover your care if you continue to use providers that are not in our network and not affiliated with your PCP's medical group.

New members to *Molina Medicare Complete Care Plus:* In most instances you will be enrolled in Molina Medicare Complete Care Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in Molina Medicare Complete Care Plus. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Molina Medicare Complete Care Plus. There will be no gap in your Medi-Cal coverage. Please call us at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time if you have any questions.

C. Your Case Manager

C1. What a Case Manager is

- A Molina Medicare Complete Care Plus Case Manager is a main person for you to contact to assist you with your care, if required. This person helps to coordinate your care and manage your services to ensure you receive the help that you require.

C2. How you can contact your Case Manager

- If you want to contact your Case Manager, please call Member Services at (855) 665-4627, 7 days a week, 8 a.m. to 8 p.m., local time. The call is free. TTY: 711. Or, visit www.molinahealthcare.com/Medicare.

C3. How you can change your Case Manager

- You may request a change in Case Manager by calling case management or member services. Molina Medicare Complete Care Plus HealthCare Services staff may make changes to member case manager assignment based on member needs or location.

D. Care from providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group.

Definition of a PCP, and what a PCP does do for you

Primary Care Provider (PCP) is a physician, nurse practitioner, or health care professional and/or medical home or clinic (Federally Qualified Health Centers - FQHC) who gives you routine health care. Molina Medicare Complete Care Plus maintains a network of specialty providers to care for its members. Referrals from a Molina Medicare Complete Care Plus PCP are required for a member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral services. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- Your X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

Your choice of PCP

Your relationship with your PCP is an important one. We strongly recommend that you choose a PCP close to home. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship easier. For a copy of the most current Provider/Pharmacy Directory, or to seek additional assistance in choosing a PCP, please contact Member Services. If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the Provider and Pharmacy Directory, or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.

You can change your PCP at any time. In most cases, changes will be in effect the first day of the following calendar month. There may be exceptions if you're currently receiving a treatment at the time of your PCP change request. You can change your PCP through your personal website at www.mymolina.com or you may contact Member Services for more information about any of our Molina Healthcare providers and request the PCP change. For some providers, you may need a referral from your PCP (except for emergent and out of area urgent care services).

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to network providers (for example, if you're outside our plan's service area or during the weekend).

Note: Urgently needed care must be immediately needed and medically necessary.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- Nurse Midwife Services, Family Planning, HIV Testing & Counseling, Treatment for Sexually Transmitted Diseases (STD's)

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists., such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.
- Gastroenterologists care for patients with digestive or intestinal problems.

- Nephrologists care for patients with kidney problems.
- Urologists care for patients with urinary and bladder problems.
- As a member you are not limited to specific specialists. Molina Medicare Complete Care Plus maintains a network of specialty providers to care for its members. Referrals from your PCP may be required to receive specialty services, members are allowed to directly access women health specialists for routine and preventive health without a referral services. For some services you may be required to get a Prior Authorization. Your PCP may request a prior authorization from Molina Healthcare's Utilization Management Department by telephone, fax, or mail based on the urgency of the requested service.
- Please refer to the Benefits Chart in **Chapter 4** for information about which services require prior authorization.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 for more information.)
- If your provider leaves our network your provider must agree to contract with our providers for you to continue to access continuity of care services.

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Call Member Services at the number at the bottom of this page.

D4. Out-of-network providers

If you need medical care and the providers in our network cannot provide this care, including Long Term Services and Supports you can get this care from an out-of-network provider. Out-of-network services require a prior authorization. You or your provider can ask for this prior authorization. Please contact Member Services for assistance. If you obtain routine care from out-of-network providers without prior authorization, neither Medicare/Medi-Cal nor the Plan will be responsible for the costs.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medi-Cal.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medi-Cal.
- If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

The plan covers kidney dialysis for End-Stage Renal Disease (ESRD) services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility. Please call Member Services so we can help you get dialysis while you are away.

Long-term services and supports (LTSS) consist of Community Based Adult Services (CBAS), and Nursing Facilities (NF). The services may occur in your home, community, or in a facility. The different types of LTSS are described below:

- **Community Based Adult Services (CBAS)**: Outpatient, facility based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services if you meet applicable eligibility criteria.
- **Nursing Facility (NF)**: A facility that provides care for people who cannot safely live at home but who do not need to be in the hospital.

Your Case Manager will help you understand each program. To find out more about any of these programs, please contact Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.

E. Behavioral health (mental health and substance use disorder) services

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare. Our plan does not provide Medi-Cal covered behavioral health services, but these services are available to you through Riverside University Health Systems – Behavioral Health, San Bernardino County Department of Behavioral Health, San Diego County- Behavioral Health Services and Los Angeles County Department of Mental Health.

E1. Medi-Cal behavioral health services provided outside our plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by Riverside University Health System – Behavioral Health, San Bernardino County Department of Behavioral Health, San Diego County- Behavioral Health Services and Los Angeles County Department of Mental Health include:

- Mental health services
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis intervention

- Crisis stabilization
- Adult residential treatment services
- Crisis residential treatment services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management

Medi-Cal or Drug Medi-Cal Organized Delivery System services are available to you through Riverside University Health System – Behavioral Health, San Bernardino County Department of Behavioral Health, San Diego County- Behavioral Health Services and Los Angeles County Department of Public Health if you meet criteria to receive these services. Drug Medi-Cal services provided by Riverside University Health System – Behavioral Health San Bernardino County Department of Behavioral Health, San Diego County- Behavioral Health Services and Los Angeles County Department of Public Health *include*:

- Intensive outpatient treatment services
- Residential treatment services
- Outpatient drug free services
- Narcotic treatment services
- Naltrexone services for opioid dependence

Drug Medi-Cal Organized Delivery System Services include:

- Outpatient and intensive outpatient services
- Medications for addiction treatment (also called Medication Assisted Treatment)
- Residential/inpatient
- Withdrawal management
- Narcotic treatment services
- Recovery services
- Care coordination

In addition to the services listed above, you may have access to voluntary inpatient detoxification services if you meet the criteria.

Molina Medicare Complete Care Plus provides access to many mental health and substance use providers. A list of providers can be located on the Molina Medicare Complete Care Plus Member website or by calling Member Services. For a copy of the most current Provider/Pharmacy Directory, or to seek additional assistance in choosing a behavioral health provider, please contact Member Services. For some services you may be required to get a Prior Authorization. You or your Behavioral Health Provider or your PCP may request a prior authorization from Molina Healthcare's Utilization Management Department by telephone, fax, or mail based on the urgency of the requested service.

Please refer to the Benefits Chart in Chapter 4 for information about which services require prior authorization. The care must be determined necessary. By necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current mental health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of behavioral health and medical practice.

If you are receiving services or need to obtain Medi-Cal specialty mental health services or drug services that are available to you through the county mental health plan (MHP), Molina Medicare Complete Care

Plus Case Managers can help refer you to the appropriate county resource for an assessment. You can call Member Services to request assistance. You can also contact the County directly. See the appropriate county numbers in the information below.

Specialty Mental Health Services

Los Angeles County Department of Mental Health 1-800-854-7771

Riverside University Health System – Behavioral Health 1-800-706-7500

San Bernardino County Department of Behavioral Health 1-888-743-1478

San Diego County Behavioral Health Services 1-888-724-7240

Drug Medi-Cal Services

Los Angeles County Department of Public Health 1-844-804-7500

Riverside University Health System – Behavioral Health 1-800-499-3008

San Bernardino County Department of Behavioral Health 1-888-743-1478

San Diego County Behavioral Health Services 1-888-724-7240

F. Transportation services

F1. Medical transportation of non-emergency situations

You are entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need non-emergency medical transportation, you can talk to your PCP or other provider and ask for it. Your PCP or other provider will decide the best type of transportation to meet your needs. If you need non-emergency medical transportation, they will prescribe it by completing a form and submitting it to Molina Medicare Complete Care Plus for approval. Depending on your medical need, the approval is good for one year. Your PCP or other provider will reassess your need for non-emergency medical transportation for re-approval every 12 months.

Non-emergency medical transportation is an ambulance, litter van, wheelchair van, or air transport. Molina Medicare Complete Care Plus allows the lowest cost covered transportation mode and most appropriate non-emergency medical transportation for your medical needs when you need a ride to your appointment. For example, if you can physically or medically be transported by a wheelchair van, Molina Medicare Complete Care Plus will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Non-emergency medical transportation must be used when:

- You physically or medically need it as determined by written authorization from your PCP or other provider because you are not able to use a bus, taxi, car, or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle, or place of treatment due to a physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call Molina Medicare Complete Care Plus Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time at least 2 days in advance, (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Medical transportation limits

Molina Medicare Complete Care Plus covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation will not be provided if Medicare or Medi-Cal does not cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, Molina Medicare Complete Care Plus will help you schedule your transportation. A list of covered services is in Chapter 4 of this handbook. Transportation is not covered outside Molina Medicare Complete Care Plus's network or service area unless pre-authorized.

F2. Non-medical transportation

Non-medical transportation benefits include traveling to and from your appointments for a service authorized by your provider. You can get a ride, at no cost to you, when you:

- Traveling to and from an appointment for a service authorized by your provider, or
- Picking up prescriptions and medical supplies.

Molina Medicare Complete Care Plus allows you to use a car, taxi, bus, or other public/private way of getting to your non-medical appointment for services authorized by your provider. We cover the lowest cost, non-medical transportation type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Molina Medicare Complete Care Plus must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling or emailing, or in person. **You cannot be reimbursed for driving yourself.**

Mileage reimbursement requires all of the following:

- The driver's license of the driver
- The vehicle registration of the driver
- Proof of car insurance for the driver

To ask for a ride for services that have been authorized, call Molina Medicare Complete Care Plus Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time at least 2 days in advance, (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Note: American Indians may contact their local Indian Health Clinic to ask for non-medical transportation.

Non medical transportation limits

Molina Medicare Complete Care Plus provides the lowest cost non medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You cannot drive yourself or be reimbursed directly.**

Non medical transportation does **not** apply if:

- An ambulance, litter van, wheelchair van, or other form of non-emergency medical transportation is needed to get to a service.
- You need assistance from the driver to and from the residence, vehicle, or place of treatment due to a physical or medical condition.
- You are in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- The service is not covered by Medicare or Medi-Cal.

G. Covered services in a medical emergency, when urgently needed, or during a disaster

G1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- Serious risk to your health or to that of your unborn child; **or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories worldwide, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We will follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay in telling us. You can find the number to Member Services on the back of your ID card.

Covered services in a medical emergency

Medicare and Medicaid do not provide coverage for emergency medical care outside the United States and its territories except under limited circumstances. Contact the plan for details.

If you need an ambulance to get to the emergency room, our plan covers that. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.

- After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by us. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible. Molina Medicare Complete

Care Plus will cover medically necessary Post-Stabilization Services that are provided by an in-network or out-of-network provider in any of the following situations:

- the plan has authorized such services
- services were administered to maintain and stabilize the member's condition

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider, **or**
- The additional care you get is considered "urgently needed care" and you follow the rules (refer to Section H2) for getting it.

G2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider, **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

When network providers are temporarily unavailable or inaccessible, urgent care can be accessed using any available urgent care center. You may also call the 24 hour Nurse Advice Line at (888) 275-8750. TTY users should call 711.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

You are covered for worldwide emergency and urgent care services up to $10,000 each calendar year. For more information, refer to the benefits chart in Chapter 4.

G3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from our plan.

Visit our website for information on how get needed care during a declared disaster: www.MolinaHealthcare.com/Medicare.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you fill your prescription drugs at an out-of-network pharmacy. Please refer to **Chapter 5** of your *Member Handbook* for more information.

H. What to do if you are billed directly for services our plan covers

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill.

You should not pay the bill yourself. If you do, we may not be able to pay you back.

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

H1. What to do if our plan does not cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to **Chapter 4**) of your *Member Handbook*, **and**
- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you use over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

I. Coverage of health care services in a clinical research study

I1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare or our plan approves a study you want to be in, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way our plan continues to cover you for services and care not related to the study.

If you want to take part in a Medicare-approved clinical research study, you do ***not*** need to get approval from us or your primary care provider. Providers that give you care as part of the study do ***not*** need to be network providers.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, you or your Case Manager should contact Member Services to let us know you will take part in a clinical trial.

I2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you volunteer for a clinical research study, we pay any costs that Medicare does not approve but that our plan approves. If you're part of a study that Medicare or our plan has **not approved**, you pay any costs for being in the study.

I3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

J. How your health care services are covered in a religious non-medical health care institution

J1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution. This benefit is only for Medicare Part A inpatient services (non-medical health care services).

J2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is **voluntary and not required** by any federal, state, or local law.

- "Excepted" medical treatment is any care that is **not voluntary and is required** under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

Our plan covers an unlimited number of days for an inpatient hospital stay. (Refer to the Benefits Chart in Chapter 4).

K. Durable medical equipment (DME)

K1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you will not own DME, no matter how long you rent it.

In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

K2. DME ownership if you switch to Original Medicare

If you didn't get ownership of the DME item while in our plan, you must make 13 new consecutive payments after you switch to Original Medicare to own the item. Payments you made while in our plan do **not** count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare **before** you joined our plan, your previous payments don't count toward the 13 consecutive payments. You must make 13 new consecutive payments after you return to Original Medicare to own the item. There are no exceptions to this case when you return to Original Medicare.

K3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

- Rental of oxygen equipment

- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

Oxygen equipment must be returned to the owner when it's no longer medically necessary for you or if you leave our plan.

K4. Oxygen equipment when you switch to Original Medicare

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months,** your supplier must provide:

- Oxygen equipment, supplies, and services for another 24 months.
- Oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period:**

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You will rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

New members to Molina Medicare Complete Care Plus (HMO D-SNP): In most instances you will be enrolled in Molina Medicare Complete Care Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in Molina Medicare Complete Care Plus. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Molina Medicare Complete Care Plus. There will be no gap in your Medi-Cal coverage. Please call us at (855) 665-4627,TTY:711 if you have any questions.

Table of Contents

A. Your covered services

This chapter tells you about services our plan covers and how much you pay for each service. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services. Because you get assistance from Medi-Cal, you pay nothing for your covered services as long as you follow our plan's rules. Refer to Chapter 3 of your Member Handbook for details about the plan's rules.

If you need help understanding what services are covered, call Member Services at (855) 665-4627.

A1. During public health emergencies

If the Governor of California, the U.S Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Molina Medicare Complete Care Plus.

Please call Member Services for information on how to obtain needed care during a disaster.

B. Rules against providers charging you for services

We don't allow our in-network providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We must provide your Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal.
- The services (including medical care, behavioral health and substance use services, long term services and supports, supplies, equipment, and drugs) must be medically necessary. "Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we do not pay for care you get from an out-of-network provider. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.

- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that is not on your PCP or use other providers in the plan's network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do not need one.
- You must get care from providers that are affiliated with your PCP's medical group. Refer to **Chapter 3** of your *Member Handbook* for more information.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization. We mark covered services in the Benefits Chart that need prior authorization in **bold**.
- If you are within our plan's (6)-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. We will continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, and we will continue to pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

Important Benefit Information for Members with Certain Chronic Conditions. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:

- Chronic alcohol and other drug dependence
- Autoimmune disorders
- Cancer
- Cardiovascular disorders
- Chronic heart failure
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- Severe hematologic disorders
- HIV/AIDS
- Chronic lung disorders
- Chronic and disabling mental health conditions
- Neurologic disorders
- Stroke

Refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information.

Most preventive services are free. You find this apple  next to preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

	Services that our plan pays for	What you must pay
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0 There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
	Acupuncture We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary. We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.	$0 You pay $0 for each Medicare-covered treatment
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

	Services that our plan pays for	What you must pay
	Ambulance services Covered ambulance services include ground, fixed-wing, and rotary-wing (helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 You pay $0 for each Medicare-covered one-way ambulance trip. **Prior authorization is only required for non-emergent ambulance transport.** If you need emergency care, dial 911 and request an ambulance. Refer to "Worldwide emergency/ urgent coverage" in this chart if you need emergency ambulance transport outside the U.S.
	Annual physical exam (Supplemental) The annual routine physical exam provides coverage for additional physical examination services that can only be rendered by a physician, nurse practitioner, or physician assistant. This is a great opportunity to focus attention on prevention and screening. During a routine physical examination, the clinician will examine you to identify problems through visual inspection, palpation, auscultation, and percussion. The last three of these involve direct physical contact and are necessary to identify the presence (or absence) of a physical condition.	$0 If additional services are required, your provider will refer you to a specialist or submit a prior authorization if needed.
	**Annual wellness visit** You should get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.	$0 There is no coinsurance, copayment, or deductible for the annual wellness visit.
	Asthma Preventive Serivces You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.	$0

	Services that our plan pays for	What you must pay
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0 There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
	Breast cancer screening (mammograms) We pay for the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	$0 There is no coinsurance, copayment, or deductible for covered screening mammograms.
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral or order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 **Prior authorization may be required.**
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the visit, your doctor may: • Discuss aspirin use, • Check your blood pressure, **and/or** • Give you tips to make sure you are eating well.	$0 There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
	Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0 There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years

	Services that our plan pays for	What you must pay
	**Cervical and vaginal cancer screening** We pay for the following services: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months • For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years	$0 There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
	Chiropractic services We pay for the following services: • Adjustments of the spine to correct alignment	You pay $0 per visit for these Medicare-covered services.
	**Colorectal cancer screening** For people 50 and older, we pay for the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening, every 3 years • Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy) • Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.	$0 There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
	Community Based Adult Services (CBAS) CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We pay for CBAS if you meet the eligibility criteria. **Note:** If a CBAS facility is not available, we can provide these services separately.	$0

	Services that our plan pays for	What you must pay
	**Counseling to stop smoking or tobacco use** If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12 month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • We pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. If you are pregnant, you may get unlimited tobacco cessation counseling with prior authorization.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
	Dental services Certain dental services, including but not limited to, cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program or FFS Medi-Cal. We offer additional dental benefits that include dental services such as cleanings, fillings, and dentures. You have a $4,000 maximum allowance each calendar year for all supplemental comprehensive and preventive dental services, including dentures. Cosmetic services are not covered by the plan, and you may not use your MyChoice card to pay for it. The allowance is to be used for services not already covered by Original Medicare or Medi-Cal (Medicaid).	You pay $0 for these services if using your MyChoice Card.
	**Depression screening** We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.	$0 There is no coinsurance, copayment, or deductible for an annual depression screening visit.

	Services that our plan pays for	What you must pay
	**Diabetes screening** We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

	Services that our plan pays for	What you must pay
	**Diabetic self-management training, services, and supplies** We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: • A blood glucose monitor • Blood glucose test strips • Lancet devices and lancets • Glucose-control solutions for checking the accuracy of test strips and monitors • We cover diabetic supplies from a preferred manufacturer without a prior authorization. We will cover other brands if you get a prior authorization from us. • For people with diabetes who have severe diabetic foot disease, we pay for the following: ◦ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ◦ One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	You pay $0 for this benefit. Supplies are covered when you have a prescription and fill it at a network retail pharmacy or through the Mail Service Pharmacy program. See “Vision care” in this chart for doctor’s services if you need an eye exam for diabetic retinopathy or a glaucoma screening. See “Podiatry services” in this chart if you are diabetic and need to see a doctor for a foot exam. See “Medical nutrition therapy” in this chart if you are diabetic and need medical nutrition therapy services (MNT). **Prior authorization may be required diabetic supplies, diabetic shoes, and inserts.** **Prior authorization is not required for Medicare-covered diabetes self-management training.**
	Doula Services For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery.	$0

	Services that our plan pays for	What you must pay
	Durable medical equipment (DME) and related supplies Refer to the last chapter of your *Member Handbook* for a definition of "Durable medical equipment (DME)," We cover the following items: • Wheelchairs including electric wheelchairs • Crutches • Powered mattress systems • Dry pressure pad for mattress • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Enteral pump and supplies • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	$0 You pay $0 for Medicare-covered DME and related supplies. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Emergency care Emergency care means services that are: • Given by a provider trained to give emergency services, **and** • Needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • Serious risk to your health or to that of your unborn child; **or** • Serious harm to bodily functions; **or** • Serious dysfunction of any bodily organ or part; **or** • In the case of a pregnant woman in active labor, when: ◦ There is not enough time to safely transfer you to another hospital before delivery. ◦ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Emergency care is only within the United States and its territories except under limited circumstances. Contact the plan for details. As an added benefit, we offer up to $10,000 of worldwide emergency coverage each calendar year for emergency transportation, urgent care, emergency care, and post-stabilization care.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay. You must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

	Services that our plan pays for	What you must pay
	Family planning services The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of a medical emergency. • Follow-up care for any problems you may have using birth control methods issued by the family planning providers. • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility and related services • Counseling, testing, and treatment for sexually transmitted infections (STIs) • Counseling and testing for HIV and AIDS, and other HIV-related conditions • Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • Genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing **This benefit is continued on the next page**	$0

	Services that our plan pays for	What you must pay
	Family planning services (continued) For information on Family Planning Services available to you in your area, call the State Department of Health Services, Office of Family Planning, toll-free at 1(800) 942-1054. • Note: Some hospitals and other providers may not provide some of the family planning services that may be covered under your plan contract. These could include family planning counseling, and birth control services including emergency contraception, sterilization(including tubal ligation at the time of labor and delivery), or abortion. Call your doctor, medical group, or clinic, or call Member Services toll-free at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time to make sure that you can get the health care services that you need.	
	Fitness Benefit (Supplemental) You get a fitness center membership to participating fitness centers. If you are unable to visit a fitness center or prefer to also work out from home, you can select a Home Fitness kit. The kit will help you keep active in the comfort of your home. If you choose to work out at a fitness center, you can view the website and select a participating location, or you can go directly to a participating fitness center to get started. Participating facilities and fitness chains may vary by location and are subject to change. Kits are subject to change.	$0 No referral or prior authorization is required to use this benefit. Always talk to your doctor before starting or changing your exercise routine.
	**Health and wellness education programs** We offer many programs that focus on certain health conditions. These include: • Health Education classes; • Nutrition Education classes; • Nursing Hotline	$0

	Services that our plan pays for	What you must pay
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. You are covered for 1 hearing exam every year, and fitting/evaluation for hearing aids 1 every 2 years under your Medi-Cal (Medicaid) benefit. Our plan covers an additional fitting/evaluation for hearing aids 1 every year. If you are told you need hearing aids, you have a hearing aid allowance of $1510 every year for both ears combined under your Medi-Cal (Medicaid) benefit. Our plan covers an additional 2 pre-selected hearing aids from a plan approved provider. If you are pregnant or reside in a nursing facility, we will also pay for hearing aids, including: • Molds, supplies, and inserts • Repairs that cost more than $25 per repair • An initial set of batteries • Six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid • Trial period rental of hearing aids	$0 **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Help with certain chronic conditions If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill. • Chronic alcohol and other drug dependence • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes • End-stage liver disease • End-stage renal disease (ESRD) • Severe hematologic disorders • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions • Neurologic disorders • Stroke You will need to submit a Health Risk Assessment form completed by your physician identifying you as having one of the listed conditions that could worsen without access to one of the special supplemental benefits listed below. The following process will need to be completed in order to qualify: Call Member Services or your Case Manager to initiate your request to access these benefits. Note: By requesting this benefit you are authorizing Molina Medicare Complete Care Plus (HMO D-SNP) representatives to contact you by phone, mail or any other methods of communication as expressly outlined in your application. Upon receiving your request to access SSBCI benefits, a Member Services Representative or your Case Manager will send a Health Risk Assessment and SSBCI referral form to be completed by your provider, if a current one is not on file with Molina Medicare Complete Care Plus (HMO D-SNP). **This benefit is continued on the next page**	$0 There is no coinsurance, co-payment, or deductible for your MyChoice Card. **Participation in a care management program may be required. Members must also have physician sign off for testing based on lack of historical medical information.** **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Help with certain chronic conditions (continued) You (the member) will need to make an appointment with your Primary Care Physician to conduct an assessment, completed your health risk assessment form and select each qualifying condition listed in the SSBCI referral form. Your Provider must complete and sign both your Health Risk Assessment and SSBCI Referral form and fax both to the number listed on the SSBCI Referral form. Molina Medicare Complete Care Plus Plus (HMO D-SNP) will send a confirmation of receipt and once approved, will notify you of the additional SSBCI funds that will be made available through your MyChoice Card. Upon approval, your MyChoice Card will be automatically loaded with up to $150 a quarter to be used towards the SSBCI benefits. The SSBCI benefits below may be combined based on your condition, but the maximum allowance amount is a total of $150 per quarter. Any unused funds at the end of each quarter will not carry over to the following quarter. **Service Animal Supplies Allowance:** Provides support to members with a disability or chronic condition who requires assistance of Service Animals. To be eligible for this benefit, our plan requires a completed HRA and confirmation of need for Service Animals. The Service Animal Supplies allowance may be used towards the purchase of animal food and supplies, from any retail or online merchant identified as a pet store (example: Petco, PetSmart, Chewy, etc.). The allowance does not cover cost of obtaining, training, or any veterinary services of the service animal. **Pest Control:** This benefit is limited to routine preventive pest control services at your current residence (at the address on file with the plan). Pest control treatment may be rendered by any provider with a registered merchant ID indicating they are a Pest Control service. **This benefit is continued on the next page**	

	Services that our plan pays for	What you must pay
	Help with certain chronic conditions (continued) Molina Medicare Complete Care Plus (HMO D-SNP)'s preferred Pest Control provider is Terminix. Terminix is contracted directly with Molina Medicare Complete Care Plus (HMO D-SNP) to provide routine preventive pest control services at a discounted rate. Members must use their MyChoice Card to pay for services. **Non-Medicare-covered Genetic Test kits:** Tests include, but are not limited to: Food sensitivity, Indoor and Outdoor allergy, Sleep and Stress, and more. This benefit is designed to help members who may not have access to their family's medical history to indicate any potential future health concerns. Members may purchase these tests at any online website with a registered merchant ID indicating they are a genetic testing provider. Molina Medicare Complete Care Plus (HMO D-SNP) has direct contracts with Everlywell to offer tests at a discounted rate. Members must use their preloaded MyChoice Card to pay for these services. **Mental Health and Wellness Applications Allowance:** Mental Health and Wellness Applications are designed to provide valuable tools to assist the members ability to manage the disability. Examples of Mental Health and Wellness Applications include: Talkspace, Headspace, Calm, etc. Members must use their preloaded MyChoice Card to purchase these applications. The SSBCI benefit below has a maximum allowance amount of $35 per month. This monthly allowance is not shared with the SSBCI benefits above. Any unused funds at the end of each month will not carry over to the following month. **This benefit is continued on the next page**	

	Services that our plan pays for	What you must pay
	Help with certain chronic conditions (continued) **Food and Produce:** If eligible, you get to spend $80 on your Food and Produce benefits. This monthly allowance is not shared with the following SSBCI services: Pest Control, Service Animal Supplies, Non-Medicare-covered Genetic Test Kit, and Mental Health & Wellness Applications. Any unused funds at the end of each month will not carry over to the following month. You can use the allowance on your MyChoice Card towards a variety of brand-name and generic healthy food products at your nearby participating localstore, or online with home delivery for no additional cost at Members.NationsBenefits.com/Molina.	
	**HIV screening** We pay for one HIV screening exam every 12 months for people who: • Ask for an HIV screening test, **or** • Are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy. We also pay for additional HIV screening(s) when recommended by your provider.	$0 There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. We pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	You pay $0 for these services. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. Our plan covers home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	You pay $0 for Medicare-covered Home infusion therapy. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider. Our plan pays for the following while you get hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • Refer to **SectionF** of this chapter for more information. **For services covered by ourplan but not covered by Medicare Part A or B:** • Our plan covers services not covered under Medicare Part A or B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook.* **Note:** If you need non-hospice care, call your Case Manager to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Molina Medicare Complete Care Plus (HMO D-SNP).

	Services that our plan pays for	What you must pay
	**Immunizations** We pay for the following services: • Pneumonia vaccine • Flu shots, once each flu season, in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID- 19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Referto **Chapter 6** of your *Member Handbook* to learn more. We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).	$0 There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
	In-Home Support Services (Supplemental) You have access to In-Home Support Services, including cleaning, household chores, meal preparation, and assistance with other instrumental activities of daily living. You have access up to 90 hours every year.	$0

	Services that our plan pays for	What you must pay
	Inpatient hospital care Our plan covers an unlimited number of days for an inpatient hospital stay. We pay for the following services and other medically necessary services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If Molina Medicare Complete Care Plus provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. For further information on transplant and covered services contact Member Services. • Blood, including storage and administration • Physician services	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • If you need inpatient services in a freestanding psychiatric hospital, we pays for the first 190 days. After that, the local county mental health agency pay for medically necessary inpatient psychiatric services that are medically necessary. Authorization for care beyond the 190 days is coordinated with the local county mental health agency. ◦ The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • If you are 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD).	$0 There is no coinsurance, copayment, or deductible for this benefit. **Prior authorization may be required.**
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We do not pay for your inpatient stay if it is not reasonable and medically necessary. However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: ◦ An internal body organ (including contiguous tissue), or ◦ The function of an inoperative or malfunctioning internal body organ. • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • Physical therapy, speech therapy, and occupational therapy	$0 There is no coinsurance, copayment, or deductible for this benefit. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, see “Medicare Part B prescription drugs” in this chart.	$0 You pay $0 for these services. Medicare covers up to 6 sessions per lifetime.
	**Lung cancer screening** Our plan pays for lung cancer screening every 12 months if you: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visits.

	Services that our plan pays for	What you must pay
	Meal Benefit (Supplemental) This benefit is meant to keep you healthy and strong after an Inpatient Hospital or Skilled Nursing Facility (SNF) stay, or for a medical condition or potential medical condition that requires you to remain at home for a period of time. Your Case Manager or your doctor will decide if you are in need of this benefit. Your doctor can request this benefit for you if you have certain chronic conditions. This benefit provides 2 meals a day for 14 days with a total of 28 meals delivered. Meal types will be based on any dietary needs you may have. You may also qualify for an additional 28 meals over 14 days with approval. Plan maximum coverage of 4 weeks, and up to 56 meals every calendar year applies. Your Case Manager will order your meals for you and they will be delivered to your home. The first delivery usually arrives within 72 hours (3 business days) of order processing. You will be contacted in advance of the delivery date(s).	$0 **Prior authorization may be required.**
	**Medical nutrition therapy** This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0 There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
	**Medicare Diabetes Prevention Program (MDPP)** Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • Long-term dietary change, **and** • Increased physical activity, **and** • Ways to maintain weight loss and a healthy lifestyle.	$0 There is no coinsurance, copayment, or deductible for the (MDPP) benefit.

	Services that our plan pays for	What you must pay
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized. • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit© or Epoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases The following link takes you to a list of Part B drugs that may be subject to step therapy: www.molinahealthcare.com/Medicare We also cover some vaccines under our Medicare Part B and Part D prescriptions drug benefit. **Chapter 5** of your *Member Handbook* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Member Handbook* explains what you pay for your outpatient prescription drugs through our plan.	$0 You pay $0 for each Medicare Part B prescription drug. **Part B drugs may be subject to step therapy.** **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	MyChoice Card The MyChoice Card is a prepaid benefit debit card that may be used to pay for select supplemental plan benefits such as: • Over-the-counter Items • Dental • Vision • Transport • Food and Produce* • Special Supplemental Benefits for Chronic Illnesses *Eligibility requirements applicable. The prepaid debit card is not a credit card. You cannot convert the card to cash or loan it to other people. Cosmetic procedures are not covered under this benefit card. Funds are loaded onto the card on each benefit period. A benefit period can be monthly or quarterly depending on the benefits. At the end of each benefit period, any unused allocated money will not carry over to the following period or plan year. If you leave the plan, any unused allocated funds revert to the plan upon your effective disenrollment date. MyChoice Card allowances may only be used to access the specified supplemental benefit up to the defined limit. This allowance may only be used by the member and may not be applied to any other benefit or costs. For more information regarding your OTC benefit or how to qualify for the Food and Produce, and Special Supplemental Benefits for Chronic Illnesses (SSBCI's), please call Molina Medicare Complete Care Plus (HMO D-SNP) Member Services. To access allowances for SSBCI's, members must have: a qualifying chronic condition; a valid HRA completed for their current Molina Medicare Complete Care Plus (HMO D-SNP) enrollment; and provide physician approval in conjunction with Molina Medicare Complete Care Plus (HMO D-SNP) Case Management.	$0

	Services that our plan pays for	What you must pay
	Nutrition counseling You can get individual telephonic nutrition counseling upon request. Your provider will need to complete and sign a Health Education Referral Form so we have a clear understanding of your needs before we call you. • Telephonic intervention is 30 to 60 minutes in length. • You will be given contact information for further information and/or follow-up as needed or desired. Nutritional/Dietary individual sessions are unlimited under your Medi-Cal (Medicaid) benefit. Our plan covers an additional 12 group/individual telephonic sessions. Your provider will refer you to an in-network dietician for these services.	$0
	Nursing facility care A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Respiratory therapy • Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • Blood, including storage and administration • Medical and surgical supplies usually given by nursing facilities • Lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • Use of appliances, such as wheelchairs usually given by nursing facilities • Physician/practitioner services • Durable medical equipment • Dental services, including dentures • Vision benefits **This benefit is continued on the next page**	$0 **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Nursing facility care (continued) • Hearing exams • Chiropractic care • Podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
	**Obesity screening and therapy to keep weight down** If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0 There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
	Opioid treatment program (OPT) services Our plan pays for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing)	$0 You pay $0 for Medicare-covered outpatient opioid treatment program services. **Prior authorization is not required for Medicare-covered outpatient opioid treatment program services, but may be needed if you require opioid treatment medications.**

	Services that our plan pays for	What you must pay
	Outpatient diagnostic tests and therapeutic services and supplies We will pay for the following services and other medically necessary services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, including storage and administration. You should talk to your provider and get a referral. • Other outpatient diagnostic tests	$0 You pay $0 for these services. **Prior authorization may be required.** **No authorization is required for outpatient lab services and outpatient x-ray services. Genetic lab testing requires prior authorization.**
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ◦ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” ◦ Sometimes you can be in the hospital overnight and still be “outpatient.” ◦ You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/media/11101 • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can’t give yourself	$0 P**rior authorization may be required.** **No authorization is required for outpatient lab services and outpatient x-ray services. Genetic lab testing requires prior authorization.**

	Services that our plan pays for	What you must pay
	Outpatient mental health care We pay for mental health services provided by: • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A nurse practitioner • A physician assistant • Any other Medicare-qualified mental health care professional as allowed under applicable state laws We pay for the following services, and maybe other services not listed here: • Clinic services • Day treatment • Psychosocial rehab services • Partial hospitalization or Intensive outpatient programs • Individual and group mental health evaluation and treatment • Psychological testing when clinically indicated to evaluate a mental health outcome • Outpatient services for the purposes of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Psychiatric consultation	$0 You pay $0 per event for non-physician outpatient mental health care and psychiatric services including monitoring drug therapy and individual or group therapy visits. **Prior authorization may be required.**
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 You pay $0 for each medically-necessary outpatient physical therapy (PT), occupational therapy (OT), and/ or speech-language (SP) visit. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Outpatient substance abuse services We pay for the following services, and maybe other services not listed here: • Alcohol misuse screening and counseling • Treatment of drug abuse • Group or individual counseling by a qualified clinician • Subacute detoxification in a residential addiction program • Alcohol and/or drug services in an intensive outpatient treatment center • Extended release Naltrexone (vivitrol) treatment	$0 P**rior authorization may be required.**
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0 You pay $0 for each covered outpatient surgery event including, but not limited to, hospital or other facility charges and physician or surgical charges. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Over-the-counter (OTC) items (Supplemental) You get $400 every quarter to spend on plan-approved OTC items, products, and medications with your MyChoice Card. See “MyChoice Card” section for more information. If you don’t use all of your quarterly benefit amount, the remaining balance will expire and not rollover to the next benefit period. Your coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages. You can order: • **Online** – visit NationsOTC.com/Molina • **By Phone** – (877) 208-9243 to speak with a Nations OTC Member Experience Advisor at (TTY 711), 24 hours a day, seven days a week, 365 days a year. • **By Mail** – Fill out and return the order form in the OTC Product Catalog. OTC items by phone, mail order, online, or in person at select retail stores. • **OTC Debit card** – At participating retail locations. Refer to your 2023 OTC Product Catalog for a complete list of plan-approved OTC items or call an OTC support person for more information. You will find important information (order guidelines) in the 2023 OTC Product Catalog.	You pay $0 for these services if using your MyChoice Card. You have $400 every quarter (3 months) to spend on plan-approved OTC items, products, and medications. A quarter, or quarterly period, last 3 months. Quarterly periods for your covered OTC benefits are: • January to March • April to June • July to September • October to December The $400 you get every quarter expires at the end of the quarterly period. It does not roll over to the next quarterly period, so be sure to spend any unused amount before the end of the quarter. You may be responsible for costs if you exceed your maximum annual allowance. Limitations and exclusions may apply.

	Services that our plan pays for	What you must pay
	Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	$0 You pay $0 for each day you qualify for Medicare-covered partial hospitalization services. You must meet certain requirements to qualify for coverage and your doctor must certify that you would otherwise need inpatient treatment This treatment is given during the day in a hospital outpatient department or community mental health center and doesn't require an overnight stay. **Prior authorization may be required.**
	Personal emergency response system (PERS) (Supplemental) PERS is an in-home medical alarm system that can get you help in an emergency. If you qualify, you will be given a mobile, cellular, or landline device and a small pendant that should be worn at all times. The pendant can be worn on the neck, wrist, or belt. With the press of a button, you will be connected to a Caring Center Representative at the monitoring company. Operators are available 24 hours a day, 7 days a week, and will stay on the line with you in the event of an emergency. Whether you need urgent medical service or a family member to assist you, the Caring Center Representative will get you the help you need. Qualified members will also receive PERSPlus service levels. Using your mobile or in-home PERS device you can activate your button for non-emergent needs. If you are feeling lonely or want to talk to someone, need help scheduling your doctor's appointment, arranging transportation, or in need of any other assistance, the Caring Center Representative will assist you and may connect you to Molina Medicare Complete Care Plus (HMO D-SNP) Member Services or your Case Manager to help you get the assistance you need.	$0 **Your Case Manager will decide if you qualify for this benefit. Prior authorization is required.**

	Services that our plan pays for	What you must pay
	Physician/provider services, including doctor's office visits We pay for the following services: • Medically necessary health care or surgery services given in places such as: ◦ Physician's office ◦ Certified ambulatory surgical center ◦ Hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider or specialist, if your doctor orders them to find out whether you need treatment • Certain telehealth services, including *additional telehealth benefits*. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Telehealth services for members with a substance use disorder or co-occurring mental health disorder • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. **This benefit is continued on the next page**	$0

	Services that our plan pays for	What you must pay
	Physician/provider services, including doctor's office visits (continued) • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**. ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**. ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before a surgery • Non-routine dental care. Covered services are limited to: ◦ Surgery of the jaw or related structures ◦ Setting fractures of the jaw or facial bones ◦ Pulling teeth before radiation treatments of neoplastic cancer ◦ Services that would be covered when provided by a physician	

	Services that our plan pays for	What you must pay
	Podiatry services We pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes In addition to your Medi-Cal (Medicaid) coverage, the plan offers an additional 12 supplemental routine foot care visits every calendar year. You don't need an underlying condition to take advantage of this benefit. Coverage includes general foot care such as corn and callous removal, cutting of toenails, treatment of cracked skin, and other foot problems.	$0 **Prior authorization may be required.**
	**Prostate cancer screening exams** For men age 50 and older, we will pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0 There is no coinsurance, copayment, or deductible for an annual PSA test.

	Services that our plan pays for	What you must pay
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Prostheses to replace all of part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect • Incontinence cream and diapers We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices. We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.	$0 You pay $0 for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. **Prior authorization may be required.**
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. We pay for respiratory services for ventilator-dependent patients.	$0 You pay $0 for each Medicare-covered pulmonary rehabilitative visit. **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	**Sexually transmitted infections (STIs) screening and counseling** We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefits.
	Skilled nursing facility (SNF) care Our plan covers Medicare and non-Medicare stays in a SNF with no prior hospitalization required. We pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 **Prior authorization may be required.**

	Services that our plan pays for	What you must pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques.	$0 You pay $0 for Medicare-covered Supervised Exercise Therapy (SET) visits. **Prior authorization may be required.**
	Transportation: Non-emergency medical transportation This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit. The forms of transportation are authorized when: • Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, **and** • Depending on the service, prior authorization may be required. Refer to Chapter 3, Section F for more information.	$0 If you need emergency care, dial 911 and request an ambulance.

	Services that our plan pays for	What you must pay
	Transportation: Non-medical transportation This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. Transportation is required for the purpose of obtaining needed medical care, including travel to dental appointments and to pick up prescription drugs. Transportation services are unlimited under your Medi-Cal (Medicaid) benefit. Our plan provides an additional $200 allowance every quarter (3 months) on your Molina MyChoice card to spend on Transportation to a health-related location at your discretion. This amount does not correspond to a set number of “rides” but can be used to purchase non-emergency transport to the benefit limit. If you don’t use all of your quarterly benefit amount, the remaining balance will expire and not rollover to the next benefit period. You may use your MyChoice card to purchase rides on ride-hailing applications, on taxi services, or towards other forms of non-emergency transport, such as bus passes, rail cards, or other forms of public transit. Members are encouraged to maximize the number of rides available through this allowance. For commonly requested destinations, like dialysis centers or physical therapy facilities, contact the providing facility directly to see if more economical transportation is available before scheduling through a ride-hailing or retail transportation service. This benefit does not limit your non-emergency medical transportation benefit.	You pay $0 for these services if using your MyChoice Card. You may be responsible for costs if you exceed your maximum annual allowance. Limitations and exclusions may apply. If you need emergency care, dial 911 and request an ambulance.

	Services that our plan pays for	What you must pay
	Urgent care Urgent care is care given to treat: • A non-emergency that requires immediate medical care, **or** • A sudden medical illness, **or** • An injury, **or** • A condition that needs care right away. If you require urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend). As an added benefit, we offer up to $10,000 of worldwide emergency coverage each calendar year for emergency transportation, urgent care, emergency care, and post-stabilization care.	$0 You pay $0 for each Medicare-covered urgently needed care visit. Your cost-share is the same for network or out-of-network urgent care services.

	Services that our plan pays for	What you must pay
	**Vision care** We pay for the following services: • One routine eye exam every year; and • Up to $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses every two years. We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • People with a family history of glaucoma • People with diabetes • African-Americans who are age 50 and older • Hispanic Americans who are 65 or older We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. We will also pay for corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant. In addition to your Medi-Cal (Medicaid) coverage, our plan provides an added $500 allowance every year for routine eye exams and eyewear combined. You can use your MyChoice card towards your vision benefits. Cosmetic services are not covered by the plan, and you may not use your MyChoice card to pay for it. The allowance is to be used for services not already covered by Original Medicare or Medi-Cal (Medicaid).	You pay $0 for these services if using your MyChoice Card.

	Services that our plan pays for	What you must pay
	**"Welcome to Medicare" preventive visit** We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • A review of your health, • Education and counseling about the preventive services you need (including screenings and shots), and • Referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0 There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
	Worldwide emergency/urgent coverage (Supplemental) As an added benefit, your coverage includes up to $10,000 every calendar year for worldwide emergent/urgent care outside of the United States (U.S.). This benefit is limited to services that would be classified as emergency or urgent care had the care been provided in the U.S. Worldwide coverage includes emergency or urgently needed care, emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility and post-stabilization care. Ambulance services are covered in situations where getting to the emergency room in any other way could endanger your health. When these situations happen, we ask that you or someone caring for you call us. We will try to arrange for network providers to take over your care as soon as your medical condition and circumstances allow. Transportation back to the U.S. from another country is not covered. Routine care and pre-scheduled or elective procedures are not covered. Foreign taxes and fees (including but not limited to, currency conversion or transaction fees) are not covered. U.S. means 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Island, and American Samoa.	$0 If you receive emergency care outside the U.S. and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan. Your cost is the cost-sharing you would pay at a network hospital. Plan maximum applies. You may need to file a claim for reimbursement of emergency/ urgent care received outside the U.S. Plan maximum of $10,000 every calendar year applies for this benefit.

E. Benefits covered outside of our plan

We don't cover the following services, but they are available through Original Medicare or Medi-Cal fee-for service.

E1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who have lived in an inpatient facility for at least 90 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

You can get transition coordination services from any CCT Lead Organization that serves the county you live in. You can find a list of CCT Lead Organizations and the counties they serve on the Department of Health Care Services website at: www.dhcs.ca.gov/services/ltc/Pages/CCT.

For CCT transition coordination services

Medi-Cal pays for the transition coordination services. You pay nothing for these services.

For services not related to your CCT transition

The provider will bill us for your services. Our plan pays for the services provided after your transition. You pay nothing for these services.

While get CCT transition coordination services, we pay for services listed in the Benefits Chart in Section D.

No change in drug coverage benefit

The CCT program does **not** cover drugs.. You continue to get your normal drug benefit through our plan. For more information, please refer to Chapter 5 of your *Member Handbook*.

Note: If you need non-CCT transition care, call your Case Manager or Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time to arrange the services. Non-CCT transition care is care not related to your transition from an institution/facility.

E2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; includes but is not limited to, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns
- Root canal therapy
- Dentures, adjustments, repairs, and relines

Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at dental.dhcs.ca.gov/ for more information.

In addition to the fee-for-service Medi-Cal Dental Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Los Angeles County. If you want more information about dental plans, need assistance identifying your dental plan, or want to change dental plans, please contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 5:00 p.m. The call is free.

Note: Our plan offers additional dental services. Refer to the Benefits Chart in **Section D** for more information.

E3. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D for more information about what we pay for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by our plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, Refer to Chapter 5 of your *Member Handbook*.

Note: If you need non-hospice care, you should call your Case Manager or Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

F. Benefits not covered by our plan, Medicare, or Medi-Cal

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medi-Cal do not for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is

not covered, you can request an appeal. For information about filing an appeal, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart our plan does not cover, the following items and services:

- Services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study or our plan covers them. Refer to **Chapter 3** page 44 of your *Member Handbook*, for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.

Chapter 5: Getting your outpatient prescription drugs

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medi-Cal. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A**. These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B**. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your Member Handbook.

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care
2. Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception.
   - Refer to Chapter 9 to learn about asking for an exception.
   - Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.
5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help you identify medical references to support the requested use of the prescribed drug.

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions **only** when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your Case Manager.

A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for your covered prescription drug.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access Medi-Cal Rx covered drugs.

If you don't have your plan ID card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you ask us to pay you back. **If you can't pay for the drug, state and federal law permit the pharmacy to issue no less than a 72-hour supply of your needed prescription in an emergency. Contact Member Services right away**. We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services or your Case Manager.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services or your Case Manager.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan’s network, you need to find a new network pharmacy.

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your Case Manager.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.

  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network, or you have difficulty accessing your drug benefits in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your Case Manager.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs not available through our plan's mail-order service are marked with **NM** in our Drug List.

Our plan's mail-order service allows you to order at least a 31-day supply of the drug and no more than a 90-day supply. A 90-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please call Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time or you can visit www.MolinaHealthcare.com/Medicare.

Usually, a mail-order prescription arrives within (14) days. Please call Member Services for help in receiving a temporary supply of your prescription at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time if your mail-order is delayed.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

   After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before it is shipped.
   - Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills, contact your pharmacy (14) days before your current prescription will run out to make sure your next order is shipped to you in time. If you have difficulty and need assistance please contact your Case Manager at (855) 665-4627, TTY: 711.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. The pharmacy will contact you by phone at the number you have provided. It is important to make sure that your pharmacy has the most current contact information.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If the prescription is related to urgently needed care
- If these prescriptions are related to care for a medical emergency
- Coverage will be limited to a 31-day supply unless the prescription is written for less

In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you generally pay the full cost when you get your prescription. You can ask us to pay you back.

If you pay the full cost for your prescription that may be covered by Medi-Cal Rx, you may be able to be reimbursed by the pharmacy once Medi-Cal Rx pays for the prescription. Alternatively, you may ask Medi-Cal Rx to pay you back by submitting the "Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)" claim. More information can be found on the Medi-Cal Rx website: medi-calrx.dhcs.ca.gov/home/.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

B. Our plan's Drug List

We have a *List of Covered Drugs.* We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare.

Most of the prescription drugs you get from a pharmacy are covered by your plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting your prescriptions through Medi-Cal Rx.

Our Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generic drugs and biosimilars work just as well as brand-name drugs or biological products and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit our plan's website at www.MolinaHealthcare.com/Medicare. The Drug List on our website is always the most current one.
- Call Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.
- Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information.

B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List. If a

drug was prescribed that is not on our Drug List, your prescription drug needs will always be evaluated under our plan's coverage policies, as well as Medicare coverage rules.

Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D) cannot pay for a drug that Medicare Part A or Part B already covers. Our plan covers drugs covered under Medicare Part A or Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medi-Cal cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. Drug List cost sharing tiers

Every drug on our Drug List is in one of five (5) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Tier 1 - Preferred Generic (lowest cost share)
- Tier 2 - Generic
- Tier 3 - Preferred Brand
- Tier 4 - Non-Preferred Drug
- Tier 5 - Specialty Tier (highest cost share)

To find out which cost-sharing tier your drug is in, look for the drug on our Drug List.

Chapter 6 of your *Member Handbook* tells the amount you pay for drugs in each cost sharing tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When

a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to Chapter 9 of your *Member Handbook*.

Prior authorization (PA) - certain criteria must be met before a drug is covered. For example, diagnosis, lab values, or previous treatments tried and failed.

Step therapy (ST) - Certain cost-effective drugs must be used before other more expensive drugs are covered. For example, certain brand-name medications will only be covered if a generic alternative has been tried first.

Quantity limit (QL) - Certain drugs have a maximum quantity that will be covered. For example, certain drugs that are approved by the FDA to be taken once daily may have a quantity limit of #30 per 30 days.

B vs. D - Some drugs may be covered under Medicare part D or B, depending on the circumstances.

1. **Limiting use of a brand-name drug when a generic version is available**

   Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug available, our network pharmacies give you the generic version.

   - We usually do not pay for the brand-name drug when there is an available generic version.
   - However, if your provider told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will not work for you, then we will cover the brand-name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your doctor must get approval from us before you fill your prescription. If you don’t get approval, we may not cover the drug.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A does not work for you, then we cover Drug B. This is called step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at www.MolinaHealthcare.com/Duals. If you disagree with our coverage or exception request decision, you may request an appeal. For more information about this, refer to section E in Chapter 9.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug might be new and haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage for the drug. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
   - is no longer on our Drug List, **or**
   - was never on our Drug List, **or**
   - is now limited in some way.
2. You must be in one of these situations:

- You were in our plan last year.
  - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
  - This temporary supply is for up to 31 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of (31) days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You are new to our plan.
  - We cover a temporary supply of your drug **during the first (90) days of your membership in our plan.**
  - This temporary supply is for up to (31) days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of (31) days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in our plan for more than (90) days, live in a long-term care facility, and need a supply right away.
  - We cover one (31)-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.

- Please note that our transition policy applies only to those drugs that are "Part D" and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access.
- To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs that we cover treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List. Or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

If a drug you take will be taken off our Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9 of your *Member Handbook*.

If you need help asking for an exception, contact Member Services or your Case Manager. If you disagree with our coverage or exception request decision, you may request an appeal (For more information about this, refer to section E in Chapter 9).

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval for a drug. (permission from Molina Medicare Complete Care Plus before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug. (you must try one drug before we cover another drug).

For more information on these drug rules, refer back to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- A new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- We learn that a drug is not safe, **or**
- A drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at www.MolinaHealthcare.com/Medicare or
- Call Member Services at the number at the bottom of the page to check our current Drug List at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.

Some changes to our Drug List happen **immediately**. For example:

- **A new generic drug becomes available**. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug stays the same. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.
  - We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to Chapter 9 of your *Member Handbook* for more information on exceptions.
- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. Contact your prescribing doctor if you receive a notification.

We may make other changes that affect the drugs you take.

We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is new to the market **and**
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a 31-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9 of your *Member Handbook*.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change does not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing home, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, contact Member Services.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is non related to your terminal prognosis and conditions. In that case our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice. Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to Chapter 4 of your *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you take another drug that does the same thing
- May not be safe for your age or gender

- Could harm you if you take them at the same time
- Have ingredients that you are or maybe allergic to
- Have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

You may take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely. In such case you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have any questions about these programs, please contact Member Services or your Case Manager.

G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or

benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter explains the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you a written decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more more about appeals and the Independent Review Organization, refer to Chapter 9 of your *Member Handbook*.

The DMP may not apply to you if you:

- Have certain medical conditions, such as cancer or sickle cell disease,
- Are getting hospice, palliative, or end-of-life care, **or**
- Live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Medi-Cal prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medi-Cal Rx, **and**
- Drugs and items covered by the plan as additional benefits.

Because you are eligible for Medi-Cal, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs.*
  - We call this the “Drug List.” It tells you:
    - Which drugs we pay for
    - Which of the five (5) tiers each drug is in
    - If there are any limits on the drugs
  - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at www.MolinaHealthcare.com/Medicare.
    - Most of the prescription drugs you get from a pharmacy are covered by Molina Medicare Complete Care Plus. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.
- **Chapter 5** of your *Member Handbook***.**
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
- Our *Provider and Pharmacy Directory***.**
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* list our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* for more information about network pharmacies.

Table of Contents

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the Part D Explanation of Benefits. We call it the Part D EOB for short. The Part D EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The Part D EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.
- **Drug price information.** This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.
- Most of the prescription drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your plan ID card.**

   Show your Molina Medicare Complete Care Plus ID card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for drugs that you paid for. You can ask us to pay you back for our share of the cost of the drug.

   Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

For more information about asking us to pay you back for our share of the cost of a drug, refer to Chapter 7 of your Member Handbook.

3. **Send us information about payments others have made for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Part D drugs for the rest of the year.

4. **Check the EOB's we send you.**

   When you get a Part D EOB in the mail, make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these Part D EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules.

There are three payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the three stages:

Stage 1: Initial Coverage Stage	Stage 2: Coverage Gap Stage	Stage 3: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, you pay for the costs of your drugs. You begin this stage after you pay a certain amount of out-of-pocket costs.	During this stage, we pay all of the costs of your drugs through December 31,2023. You begin this stage when you have paid a certain amount of out-of-pocket costs.

C1. Our cost-sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our Drug List is in one of five (5) cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Tier 1 (Preferred Generic) drugs have the lowest copay. The copay is from $0.

- Tier 2 (Generic) The copay is $0, $1.45, or $4.15 for generic drugs (including brand drugs treated as generic) to $0, $4.30 or $10.35 copay for all other drugs per prescription, depending on your income.
- Tier 3 (Preferred Brand) The copay is $0, $1.45, or $4.15 for generic drugs (including brand drugs treated as generic) to $0, $4.30, or $10.35 copay for all other drugs per prescription.
- Tier 4 (Non-Preferred drug) The copay is $0, $1.45, or $4.15for generic drugs (including brand drugs treated as generic) to $0, $4.30, or $10.35 copay for all other drugs per prescription.
- Tier 5 (Specialty Tier) drugs have the highest copay. The copay is $0, $1.45, or $4.15 for generic drugs (including brand drugs treated as generic) to $0, $4.30, or $10.35 copay for all other drugs per prescription.

Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of five (5) tiers. You have no copays for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that. Refer to Chapter 9 to learn about how to file an appeal if you are told a drug will not be covered.

To learn more about these pharmacy choices, refer to **Chapter 5** of your *Member Handbook* and our *Provider and Pharmacy Directory.*

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your Member Handbook or our Provider and Pharmacy Directory.

C4. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.
Contact Member Services to find out how much your copay is for any covered drug.

Most of the prescription drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.

Your share of the cost when you get a one-month supply of a covered prescription drug from:

Tier	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	$0	$0	$0	$0
Cost-sharing Tier 2 (Generic)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $ 0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-sharing Tier 3 (Preferred Brand)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.

Tier	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details.
Cost-sharing Tier 4 (Non-Preferred drug)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-sharing Tier 5 (Specialty Tier)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.

Your share of the cost when you get a long-term supply of a covered prescription drug from:

Tier	**Standard retail cost-sharing (in-network)** (90-day supply)	**Mail-order cost-sharing** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$0	$0

Tier	Standard retail cost-sharing (in-network) (90-day supply)	Mail-order cost-sharing (90-day supply)
Cost-Sharing Tier 2 (Generic)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-Sharing Tier 3 (Preferred Brand)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-Sharing Tier 4 (Non-Preferred Drug)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in tier five (5).	Mail-order is not available for a long term supply of drugs in tier five (5).

For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D. Stage 1: The Initial Coverage Stage

Most of our members get "Extra Help" with their prescription drug costs. You will pay no separate drug deductible because this "Extra Help" pays for most drugs costs. However, you may still pay a low income subsidy (LIS) copay prior to reaching the Initial Coverage Stage.

During the Initial Coverage Stage, we pay a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's Drug List is in one of five (5) cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of five (5) tiers. You have no copay for prescription and OTC drugs on our Drug List. To find the tiers for your drugs, refer to our Drug List.

- Tier 1 - Preferred Generic (lowest cost share)

- Tier 2 - Generic
- Tier 3 - Preferred Brand
- Tier 4 - Non-Preferred Drug
- Tier 5 - Specialty Tier (highest cost share)

D1. Your Pharmacy Choices

How much you pay for a drug depends on if you get the drug from:

- A network pharmacy **or**
- An out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that.

To learn more about these choices, refer to **Chapter 5** of your *Member Handbook* and to our *Provider and Pharmacy Directory*.

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 or the *Provider and Pharmacy Directory*.

D3. What you pay

During the Initial Coverage Stage, you will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

You can contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 31-day supply	**Our plan’s mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	$0	$0	$0	$0

	A network pharmacy A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details.
Cost-sharing Tier 2 (Generic)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $ 0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-sharing Tier 3 (Preferred Brand)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-sharing Tier 4 (Non-Preferred drug)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.

	A network pharmacy A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details.
Cost-sharing Tier 5 (Specialty Tier)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.

Your share of the cost when you get a long-term supply of a covered prescription drug from:

Tier	Standard retail cost-sharing (in-network) (90-day supply)	Mail-order cost-sharing (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$0	$0
Cost-Sharing Tier 2 (Generic)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-Sharing Tier 3 (Preferred Brand)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.

Tier	Standard retail cost-sharing (in-network) (90-day supply)	Mail-order cost-sharing (90-day supply)
Cost-Sharing Tier 4 (Non-Preferred Drug)	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.	$0, $1.45, or $4.15 copay for generic drugs (including brand drugs treated as generic) $0, $4.30, or $10.35 copay for all other drugs per prescription.
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in tier five (5).	Mail-order is not available for a long term supply of drugs in tier five (5).

For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$4,660.00**. At that point, the Coverage Gap Stage begins.

Your EOBs will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the **$4,660.00** limit. Many people do not reach it in a year. At the start of each new calendar year, the amount of money you have paid in your Initial Coverage Stage will reset to zero.

E. Stage 2: The Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount ($7,400.00), you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Some information in this *Member Handbook* about the costs for Part D prescription drugs may not apply to you because you are eligible for Medi-Cal (Medicaid), and are getting "Extra Help" from Medicare to pay for prescription drug plan costs. Your drug costs in the Coverage Gap stage depends on the level of "Extra Help" you receive. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

F. Stage 3: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of **$7,400.00** for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

G. Your drug costs if your doctor prescribes less than a full month's supply

In some cases, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay will be based on the number of days of the drug that you get. We will calculate the amount you pay per day for your drug (the "daily cost sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is a little less than $0.05 per day. If you get a 7 days' supply of the drug, your payment will be a little less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you:
  - better plan when to refill your drugs,
  - coordinate refills with other drugs you take, **and**
  - take fewer trips to the pharmacy.

H. Prescription cost-sharing assistance for persons with HIV/AIDS

H1. The AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) helps eligible individuals living with HIV/AIDS access life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Department of Public Health, Office of AIDS for individuals enrolled in ADAP.

H2. If you are not enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, call 1-844-421-7050 or check the ADAP website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

H3. If you are enrolled in ADAP

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. To be sure you continue getting this assistance, notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. If you need help finding the nearest ADAP enrollment site and/or enrollment worker, call 1-844-421-7050 or check the website listed above.

I. Vaccinations

Important Message About What You Pay for Vaccines

Our plan covers most Medicare Part D vaccines at no cost to you. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

I1. What you need to know before you get a vaccination

We recommend that you call Member Services if you are plan to get a vaccination.

- We can tell you about how our plan covers your vaccination and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Part D vaccine.

I2. What you pay for a vaccination covered by Medicare Part D

covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4**.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - You pay nothing for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
   - You pay nothing to the doctor for the vaccine.
   - Our plan will pay for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.

3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
   - You will pay nothing for the vaccine.
   - Our plan will pay for the cost of giving you the shot.

Chapter 7: Asking us to pay for your services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs

Our network providers must bill the health plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services or your Case Manager if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider** refer to Chapter 3, Section D4.

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you already paid for the service, we will pay you back.
   - Refer to **Chapter 5** of your Member Handbook to learn more about out-of-network pharmacies.

2. **When a network provider sends you a bill**

   Network providers must always bill us. Show your plan ID card when you get any services or prescriptions. Improper or inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. **Call Member Services if you get any bills. Do not pay the bill.**

   - Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
   - Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
   - If you already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. **When you use an out-of-network pharmacy to get a prescription filled**

   If you use an out-of-network pharmacy, you pay the full cost of your prescription.

   - In only a few cases, we cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.

- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

4. **When you pay the full prescription cost because you don't have your plan ID card with you**

   If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

   - If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
   - Send us a copy of your receipt when you ask us to pay you back.

5. **When you pay the full prescription cost for a drug that's not covered**

   You may pay the full prescription cost because the drug isn't covered.

   - The drug may not be on our *List of Covered Drugs* (Drug List,) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
     - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
     - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
   - Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide the service or drug should be covered, we pay for it. If we deny your request for payment, you can appeal our decision.

To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook.*

B. Sending us a request for payment

Send us your bill and proof of any payment you made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your Case Manager for help.

Mail your request for payment together with any bills or receipts to this address:

For Medical Services:

Attn: Molina Medicare Services
200 Oceangate, Suite 100
Long Beach, CA 90802

For Part D (Rx) Services:
Molina Healthcare
Attn: Pharmacy Department
7050 Union Park Center, Suite 200
Midvale, UT 84047

You must submit your claim to us within 365 days of the date you got the service and/or item, **or within 36 months** of the date you got the drug.

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug is and you followed all the rules for getting it, we pay for it. If you have already paid for the service or drug, we will mail you a check for what you paid. If you haven't paid, we pay the provider directly.

Chapter 3 of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making appeal." You can also make an appeal if you don't agree with the amount we pay.

- The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*.
- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- If you want to make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in Spanish, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Tagalog, Vietnamese, Arabic and in formats such as large print, braille, or audio. To make a standing request to get materials in a language other than English or in an alternate format now and in the future, please contact Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.
- You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request so you do not need to make separate requests each time we send you information. To get this document in a language other than English, please contact the State at (800) 541-5555, TTY: 711, Monday – Friday, 8 a.m. to 5 p.m., local time) to update your record with the preferred language. To get this document in an alternate format, please contact Member Services at ((855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time. A representative can help you make or change a standing request. You can also contact your Case Manager for help with standing requests.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.

A. Su derecho a obtener información de una manera que cumpla con sus necesidades

Debemos informarle acerca de los beneficios del plan y sus derechos de una manera que pueda entender. Debemos informarle acerca de sus derechos cada año que esté en nuestro plan.

- Para obtener información de una forma que sea comprensible para usted, llame al Departamento de Servicios para Miembros. Nuestro plan cuenta con personal que puede responder a sus preguntas en diferentes idiomas.
- Nuestro plan también puede proporcionarle materiales en español, armenio, camboyano, chino, persa, coreano, ruso, tagalo, vietnamita, árabe y en formatos como letra de molde grande, sistema Braille o audio. Para solicitar materiales en un idioma que no sea inglés o en un formato alternativo ahora y en el futuro, póngase en contacto con el Departamento de Servicios para Miembros al (855) 665-4627, TTY: 711, 7 días a la semana, de 8:00 a.m. a 8:00 p.m., hora local.

- Usted puede pedir que siempre le enviemos información en el idioma o formato que necesite. Esto se conoce como una solicitud permanente. Realizaremos un seguimiento de su solicitud permanente de modo que usted no necesite hacer solicitudes por separado cada vez que le enviemos información. Para obtener este documento en un idioma que no sea inglés, comuníquese con el Estado al (800) 541-5555, TTY: 711, de lunes a viernes, de 8.00 a. m. a 5.00 p. m., hora local) para actualizar su registro con el idioma que usted prefiere. Para obtener este documento en un formato alternativo, comuníquese con el Departamento de Servicios para Miembros al (855) 665-4627, TTY: 711, 7 días a la semana, de 8.00 a. m. a 8.00 p. m., hora local. Un representante puede ayudarlo a realizar o cambiar una solicitud permanente. También puede comunicarse con su administrador de casos para obtener ayuda con respecto a la solicitud permanente.

Si tiene problemas para obtener información de nuestro plan debido a problemas con el idioma o por una discapacidad y desea presentar una queja, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede presentar una queja con Medi-Cal llamando al mediador de Cal MediConnect al 1-855-501-3077. Los usuarios de TTY deben llamar al 711.

A. May karapatan kayong kumuha ng impormasyon sa paraang matutugunan ang inyong mga pangangailangan

Dapat naming ipaalam sa inyo ang mga benepisyo ng plano at ang inyong mga karapatan sa paraang inyong mauunawaan. Dapat naming sabihin sa inyo ang tungkol sa inyong mga karapatan sa bawat taon na kayo ay miyembro ng aming plano.

- Upang kumuha ng impormasyon sa paraang mauunawaan ninyo, tumawag sa Mga Serbisyo sa Miyembro. Ang aming plano ay may mga taong makasasagot sa mga tanong sa iba't ibang wika.
- Makakapagbigay rin sa inyo ang aming plano ng mga materyales sa wikang Espanyol, Armenian, Cambodian, Chinese, Farsi, Koreano, Ruso, Tagalog, Vietnamese, Arabe at sa mga format gaya ng malaking print, braille, o audio. Upang gumawa ng pangmatagalang kahilingang makuha ang mga materyales sa isang wikang hindi Ingles o sa isang alternatibong format ngayon at sa hinaharap, mangyaring makipag-ugnayan sa Mga Serbisyo sa Miyembro sa (855) 665-4627, TTY: 711, Lunes - Biyernes, 8 a.m. hanggang 8 p.m., lokal na oras .
- Maaari ninyong hilingin na ipadala namin palagi sa inyo ang impormasyon sa wika o format na gusto ninyo. Tinatawag itong palagiang kahilingan. Susubaybayan namin ang inyong palagiang kahilingan para hindi na ninyo kailanganing gumawa ng mga hiwalay na kahilingan sa bawat pagkakataong may ipapadala kaming impormasyon sa inyo. Upang makakuha ng dokumentong ito sa ibang wika maliban sa Ingles, mangyaring makipag-ugnayan sa Estado sa (800) 541-5555, TTY: 711, Lunes – Biyernes, 8 a.m. hanggang 5 p.m., lokal na oras upang ma-update ang inyong rekord sa gustong wika. Upang makakuha ng dokumentong ito sa alternatibong format, mangyaring makipag-ugnayan sa Mga Serbisyo sa Miyembro sa (855) 665-4627, TTY: 711, Lunes – Biyernes, 8 a.m. hanggang 8 p.m., lokal na oras. Matutulungan kayo ng isang kinatawang gawin o baguhin ang palagiang kahilingan. Maaari din kayong makipag-ugnayan sa inyong Tagapamahala ng Kaso para sa tulong sa mga palagiang kahilingan.

Kung nahihirapan kayong kumuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto ninyong maghain ng reklamo, tumawag sa Medicare sa 1-800-MEDICARE (1-800-633-4227). Matatawagan ninyo ito 24 na oras sa isang araw, 7 araw sa isang linggo. Dapat

tumawag ang mga gumagamit ng TTY sa 1-877-486-2048. Maaari din kayong maghain ng reklamo sa Medi-Cal sa pamamagitan ng pagtawag sa Cal MediConnect Ombudsman sa 1-855-501-3077. Dapat tumawag ang mga gumagamit ng TTY sa 711.

A. Quý vị có quyền nhận thông tin theo cách thức đáp ứng nhu cầu của mình

Chúng tôi phải cho quý vị biết về phúc lợi của chương trình và quyền của quý vị theo cách quý vị có thể hiểu được. Chúng tôi phải thông báo với quý vị về các quyền của quý vị mỗi năm quý vị tham gia chương trình của chúng tôi.

- Để nhận được thông tin theo cách quý vị có thể hiểu được, hãy gọi Dịch vụ Thành viên. Nhân viên trong chương trình của chúng tôi có thể trả lời các câu hỏi bằng nhiều ngôn ngữ khác nhau.
- Chương trình của chúng tôi cũng có thể cung cấp cho quý vị tài liệu bằng tiếng Tây Ban Nha, tiếng Armenia, tiếng Campuchia, tiếng Trung, tiếng Farsi, tiếng Hàn, tiếng Nga, tiếng Tagalog, tiếng Việt, tiếng Ả Rập và ở các định dạng như bản in khổ lớn, chữ nổi braille hoặc âm thanh. Để đưa ra yêu cầu nhận tài liệu bằng ngôn ngữ khác không phải là tiếng Anh hoặc ở định dạng khác hiện giờ hoặc trong tương lai, vui lòng liên hệ với Dịch vụ Thành viên theo số (855) 665-4627, TTY: 711, Thứ Hai - Thứ Sáu, 8 giờ sáng đến 8 giờ tối, giờ địa phương .
- Quý vị có thể yêu cầu chúng tôi luôn gửi thông tin bằng ngôn ngữ hoặc ở định dạng quý vị cần. Đây được gọi là yêu cầu cụ thể. Chúng tôi sẽ luôn theo dõi yêu cầu cụ thể của quý vị. Như vậy, quý vị sẽ không cần tạo yêu cầu riêng mỗi lần chúng tôi gửi thông tin cho quý vị nữa. Để nhận tài liệu này ở một ngôn ngữ khác Tiếng Anh, vui lòng liên hệ với Tiểu Bang theo số (800) 541-5555, TTY: 711, Thứ Hai – Thứ Sáu, từ 8 giờ sáng đến 5 giờ chiều, giờ địa phương để cập nhật hồ sơ của quý vị bằng ngôn ngữ ưu tiên. Để nhận tài liệu này ở định dạng khác, vui lòng liên hệ với Bộ Phận Dịch Vụ Thành Viên theo số (855) 665-4627, TTY: 711, Thứ 2 – Thứ 6, 8 giờ sáng đến 8 giờ tối, giờ địa phương. Nhân viên đại diện có thể giúp quý vị tạo hoặc thay đổi yêu cầu cụ thể. Quý vị cũng có thể liên hệ với Người Phụ Trách Hồ Sơ để được trợ giúp về yêu cầu cụ thể.

Nếu quý vị gặp rắc rối về việc nhận thông tin từ chương trình của chúng tôi do vấn đề về ngôn ngữ hoặc khuyết tật và muốn nộp đơn khiếu nại, hãy gọi cho Medicare theo số 1-800-MEDICARE (1-800-633-4227). Quý vị có thể gọi 24 giờ/ngày, 7 ngày/tuần. Người dùng TTY vui lòng gọi số 1-877-486-2048. Quý vị cũng có thể nộp đơn khiếu nại cho Medi-Cal bằng cách gọi cho Cal MediConnect Ombudsman theo số 1-855-501-3077. Người dùng TTY vui lòng gọi số 711.

A.본인의 필요를 충족하는 방식으로 정보를 얻을 권리

당사는 회원님이 이해할 수 있는 방식으로 플랜의 혜택 및 회원님의 권리를 설명해야 합니다. 당사에는 플랜 가입 기간 중 매년 회원님의 권리에 대해 회원님께 안내해야 할 의무가 있습니다.

- 회원님께서 이해할 수 있는 방식으로 정보를 제공 받으려면 회원 서비스에 전화하십시오. 본 플랜에는 여러 가지 언어로 질문에 답해 드릴 수 있는 직원이 있습니다.
- 본 플랜에서는 또한 스페인어, 아르메니아어, 캄보디아어, 중국어, 페르시아어, 한국어, 러시아어, 타갈로그어, 베트남어, 아랍어로 된 자료와 큰 활자, 점자 또는 음성 자료를 제공해 드릴 수 있습니다. 현재나 향후에 영어 이외의 언어로 된 문서 또는 다른 형식의 문서를 요청하시려면 (855) 665-4627, TTY: 711, 월요일~금요일, 현지 시간으로 오전 8시~오후 8시에 . 회원 서비스로 연락하십시오.

- 항상 필요한 언어 또는 형식으로 정보를 보내 달라고 요청할 수 있습니다. 이를 상시 요청이라고 합니다. 당사는 정보를 전송할 때마다 귀하가 별도의 요청을 할 필요가 없도록 귀하의 상시 요청을 계속 추적합니다. 이 문서를 영어 이외의 언어본으로 받으시려면 (800) 541-5555(TTY: 711)번으로 월요일~금요일, 오전 8시~오후 5시(현지 시간)에 주 정부에 연락하여 원하는 언어로 기록을 업데이트하시기 바랍니다. 이 문서를 다른 형식으로 받으시려면 회원 서비스에 (855) 665-4627(TTY: 711, 월요일~금요일, 오전 8시~오후 8시(현지 시간)로 연락해서 최신 의약품 목록을 확인합니다. 담당자가 귀하의 상시 요청 신청 또는 변경을 도와드립니다. 케이스 관리자에게 문의하여 상시 요청에 대한 도움을 받을 수도 있습니다.

언어 문제 또는 장애 때문에 당사 플랜으로부터 정보를 얻는 데 어려움이 있으셔서 불만을 제기하고자 하시는 경우 1-800-MEDICARE(1-800-633-4227)번으로 Medicare에 전화해 주십시오. 상담 전화는 하루 24시간, 연중무휴 운영됩니다. TTY 사용자는 1-877-486-2048번으로 전화하십시오. 또한 Medi-Cal과 관련한 불만을 제기하시려면 Cal MediConnect Ombusman에 1-855-501-3077번으로 전화하십시오. TTY 사용자는 711번으로 전화하십시오.

A. Вы имеете право получать информацию любым удобным вам способом

Мы должны сообщать вам об объеме покрываемых услуг в рамках плана и ваших правах понятным для вас способом. Мы должны сообщать вам о ваших правах каждый год в течение всего времени вашего участия в плане.

- Чтобы получить информацию понятным для вас способом, позвоните в отдел обслуживания участников. В рамках нашего плана работают специалисты, которые могут предоставить информацию на различных языках.
- Материалы по нашему плану также доступны на испанском, армянском, камбоджийском, китайском, фарси, корейском, русском, тагальском, вьетнамском, арабском языках и в разных форматах, включая крупный шрифт, шрифт Брайля или аудиоформат. Чтобы подать запрос о предоставлении вам материалов на языке, отличном от английского, или в другом формате (в данный момент или в будущем), свяжитесь с отделом обслуживания участников по телефону (855) 665-4627, номер TTY: 711, с понедельника по пятницу, с 08:00 до 20:00 по местному времени .
- Вы можете попросить о том, чтобы мы всегда отправляли вам информацию на выбранном языке или в нужном формате. Это называется «постоянный запрос». Мы внесем такой постоянный запрос в систему, и вам не придется делать отдельные запросы каждый раз, когда мы будем направлять вам информацию. Чтобы получить данный документ на языке, отличном от английского, позвоните по тел. (800) 541-5555, TTY: 711, с понедельника по пятницу, с 08:00 до 17:00 по местному времени, и попросите внести в свою карту предпочитаемый язык. Чтобы получить данный документ в другом формате, обратитесь в отдел обслуживания участников по тел. (855) 665-4627, TTY: 711, с понедельника по пятницу, с 8:00 до 20:00 по местному времени. Представитель компании поможет создать или изменить постоянный запрос. Также за помощью в работе с постоянными запросами вы можете обращаться к координатору медицинских услуг.

Если у вас возникнут трудности при получении информации от сотрудников нашего плана из-за языковых проблем или нарушения здоровья и вы захотите подать жалобу, позвоните в Medicare по телефону: 1-800-MEDICARE (1-800-633-4227). Вы можете звонить круглосуточно в любой день недели. Телефон для пользователей телетайпа (TTY): 1-877-486-2048. Подать жалобу на Medi-Cal

можно, позвонив представителю программы Cal MediConnect по телефону 1-855-501-3077. Номер TTY для лиц с нарушениями слуха: 711.

A. 您有權以滿足您需求的方式獲得資訊

我們必須以您可以理解的方式，告知您有關計劃福利和您的權利的資訊。我們必須每年告知您，關於您在我們的計劃中擁有的權利。

- 如果您想以自己能夠理解的方式獲得資訊，請致電會員服務部。我們計劃內的人員可以用不同語言回答您的問題。
- 我們的計劃也可以爲您提供西班牙文、亞美尼亞語、柬埔寨語、中文、波斯文、韓文、俄文、塔加洛語、越南文和阿拉伯文版本的資料，以及大字體、點字或音訊格式。如果要求現在和以後接收非英文版本或其他格式的資料，請致電會員服務部 (855) 665-4627，TTY：711，服務時間爲：週一至週五上午 8 點至晚上 8 點（當地時間）.
- 我們提供您所需語言或格式版本的資訊，歡迎隨時索取。此爲長期要求。我們會持續追蹤您的長期要求，這樣您就無需每次在寄送資訊時另外提出要求。如需此文件的非英文版本，請致電聯絡州辦公室，電話： (800) 541-5555，TTY：711，週一至週五上午 8:00 至下午 5:00（當地時間），以更新您偏好語言的記錄。如需此文件的其他版本，請致電聯絡會員服務部，電話： (855) 665-4627，TTY：711，服務時間爲：週一至週五上午 8:00 至晚上 8:00（當地時間）。會有代表人員協助您提出長期要求或進行變更。您也可以聯絡案例經理，取得長期要求的相關協助。

如果您由於語言問題或殘障而無法獲得我們計劃的相關資訊，並且您想要提出上訴，請致電 Medicare，電話號碼爲 1-800-MEDICARE (1-800-633-4227)。我們 24 小時全天候接聽您的電話。TTY 使用者應致電 1-877-486-2048。您還可以透過以下方式向 Medi-Cal 提出投訴：致電 Cal MediConnect Ombudsman，電話號碼爲 1-855-501-3077。 TTY 使用者請撥 711.

أ- حقك في الحصول على المعلومات بطريقة تلبي احتياجاتك

يتعين علينا إخبارك بشأن مزايا الخطة وكذلك حقوقك بطريقة تستطيع استيعابها. يتعين علينا إخبارك بحقوقك كل عام تكون فيه عضوًا بخطتنا.

- يمكن الحصول على المعلومات بطريقة تستطيع استيعابها والاتصال بقسم خدمات الأعضاء، فخطتنا تضم أفرادًا بمقدورهم الإجابة عن الأسئلة بلغات مختلفة.
- كما يمكن أن توفر لك خطتنا المواد باللغات الإسبانية والأرمينية والكمبودية والصينية والفارسية والكورية والروسية والتاغالوغية والفيتنامية والعربية وبتنسيقات مثل المطبوعات الكبيرة أو طريقة برايل أو بالتنسيق الصوتي. لتقديم طلب دائم للحصول على مواد بلغة أخرى خلاف اللغة الإنجليزية أو بتنسيق مختلف الآن وفي المستقبل، يُرجى الاتصال بخدمات الأعضاء على الرقم (855) 665-4627 ، لمستخدمي أجهزة الهواتف النصية: 711، من الإثنين إلى الجمعة، من 8 صباحًا إلى 8 مساءً حسب التوقيت المحلي.
- يمكنك أن تطلب منا أن نرسل لك المعلومات دائمًا باللغة أو التنسيق الذي تحتاجه. ويسمى هذا طلبًا مستمرًا. وسوف نتتبع طلبك المستمر لذا فإنك لا تحتاج إلى تقديم طلبات منفصلة في كل مرة نرسل إليك بها معلومات. للحصول على هذه الوثيقة بلغة أخرى غير اللغة الإنجليزية، يرجى الاتصال بالولاية على الرقم (800) 541-5555، وبالنسبة لمستخدمي أجهزة الهواتف النصية: 711، من الإثنين حتى الجمعة، من الساعة 8 صباحًا حتى 5 مساءً حسب التوقيت المحلي) لتحديث السجل الخاص بك باللغة المفضلة. للحصول على هذه الوثيقة بتنسيق بديل، يُرجى الاتصال بقسم خدمات الأعضاء على الرقم (855) 665-4627، ولمستخدمي أجهزة الهواتف النصية: 711، من الإثنين حتى الجمعة، من الساعة 8 صباحًا حتى 8 مساءً حسب التوقيت المحلي. ويمكن لأحد المندوبين مساعدتك في تقديم طلب مستمر أو تغييره. كما يمكنك الاتصال بمدير حالتك لمساعدتك بشأن تقديم طلبات مستمرة.

إذا واجهت صعوبة في الحصول على معلومات من خطتنا بسبب مشكلات تتعلق باللغة أو إعاقة ما وتود تقديم شكوى بهذا الشأن، فالرجاء الاتصال ببرنامج Medicare على الرقم 1-800-MEDICARE 1-800-633-4227. يُمكنك الاتصال بنا على مدار 24 ساعة في اليوم، 7 أيام في الأسبوع. بالنسبة لمستخدمي أجهزة الهواتف النصية، يرجى الاتصال على الرقم 1-877-486-2048. كما يمكنك التقدم بشكواك إلى برنامج Medi-Cal عن طريق الاتصال ببرنامج Cal MediConnect Ombudsman على الرقم 1-855-501-3077. بالنسبة لمستخدمي أجهزة الهواتف النصية، يتعين عليهم الاتصال على رقم 711.

A. សិទ្ធិរបស់អ្នកដើម្បីទទួលហានព័ត៌មានតាមរបៀបដលៃបំពញេតម្រូវការរបស់អ្នក

យើងត្រូវតប្រែរាប់លាកអ្នកអំពីអត្ថបរយោជន៍នតៃមរាង និងសិទ្ធិរបស់អ្នកនៅកនុងវិធីដលៃអ្នកអាចយល់ហាន។ យើងខ្ញុំត្រូវតៃ
បរាប់លាកអ្នកអំពីសិទ្ធិរបស់លាកអ្នក កនុងមួយឆ្នាំៗ ដាយសារលាកអ្នកនៅកនុងគមរាងយើងខ្ញុំ ។

- ដើម្បីទទួលហានព័ត៌មានតាមវិធីដលៃផ្តើឲ្យលាកអ្នកអាចយល់ហាន សូមហៅទូរស័ព្ទមកកាន់សវោកម្មបម្រើសមាជិក ។
  គមរាងរបស់យើងមានមនុស្សជាច្រើនដលៃអាចឆ្លើយសំណួរជាភាសាផ្សងៗហាន។
- គមរាងរបស់យើងក៏អាចផ្តល់ឲ្យអ្នកនូវឯកសារជា ភាសាអេស្ប៉ាញ អាមនើ ខ្មរែ ចិន ហ្វាសី ក៊ូរ៉ រុស្សី តាកាឡុក
  វៀតណាម អារ៉ាប់ ហើយមានទរង់ទ្រាយជាការហៃពុម្ពធំ អក្សរសម្រាប់មនុស្សពិការភ្នកែ ឬសម្លងៃ។
  ដើម្បីសុនីសុំដើម្បីទទួលហានឯកសារ ជាភាសាណាមួយក្រៅពីភាសាអង់គ្លសេឬទម្រង់ផ្សងៃទៀតនៅពលេនេះ
  និងពលេអនាគត សូមទាក់ទងទៅសវោកម្មសមាជិក (855) 665-4627, TTY៖ 711 ពីច្រងៃចន្ទ - ច្រងៃសុក្រពីម៉ាង 8
  ព្រឹក ដល់ម៉ាង 8 យប់ ម៉ាងកនុងស្រុក។.
- ដើម្បីដាក់សំណើរដើម្បីទទួលហានឯកសារ ជាភាសាណាមួយក្រៅពីភាសាអង់គ្លសេ ឬទម្រង់ផ្សងៃទៀតនៅ ពលេបច្ចុប្បន្ន
  និងពលេអនាគត សូមទាក់ទងទៅសវោកម្មសមាជិក (855) 665-4627, TTY៖ 711 ពីច្រងៃចន្ទ - ច្រងៃសុក្រពីម៉ាង 8
  ព្រឹក ដល់ម៉ាង 8 យប់ម៉ាងកនុងស្រុក។.
- អ្នកអាចសុនីសុំអាយពួកយើងផ្ញើអាយអ្នកជានិច្ចនូវព័ត៌មានជាភាសា ឬទម្រង់ដលៃអ្នកតូ្រវការ។ តូ្រវនេះគហៅថា
  ការសំណូមពរជាអចិន្ត្រៃយ៍។ ពួកយើងនឹងបន្តតាមដានចំពោះសំណើជាអចិន្ត្រៃយ៍របស់អ្នក
  ដូច្នេះអ្នកមិនចាំហាច់បង្កើតសំណើដាច់ដាយឡែកៃរាល់ពលេដលៃយើងផ្ញើពត៌មានទៅកាន់អ្នកឡើយ។
  ដើម្បីទទួលហាងកសារនេះជាភាសាដលៃមិនមនែជាភាសាអង់គ្លសេនោះ សូមទំនាក់ទំនងទៅកាន់រដ្ឋបតាមលខេ(800)
  541-5555, TTY៖ 711 ច្រងៃច័ន្ទ ដល់ច្រងៃសុក្រ ម៉ាង8 ព្រឹក ដល់ 5 លុងាច ម៉ាងកនុងស្រុក)
  ដើម្បីជ្រាបច្ចុប្បន្នភាពទិន្នន័យរបស់អ្នកជាមួយភាសាដលៃចង់ហាន។ ដើម្បីទទួលហាងកសារនេះជាទម្រុងផ្សងៃនោះ
  សូមទំនាក់ទំនងទៅកាន់សវោសមាជិកតាមលខេ(855) 665-4627, TTY៖ 711 ច្រងៃច័ន្ទដល់ ច្រងៃសុក្រ ម៉ាង 8 ព្រឹកដល់
  8 យប់ ម៉ាងកនុងស្រុក។ អ្នកតំណាងមនាក់អាចជួយអ្នកកនុងការបង្កើត ឬផ្លាស់បតូរសំណើដលៃមានជាអចិន្ត្រៃយ៍នេះ។
  អ្នកក៏អាចទាក់ទងទៅកាន់អ្នកគ្រប់គ្រងសំនុំរឿងរបស់អ្នកដើម្បីជួយជាមួយនឹងការដាក់សំណើរ។

បរសិនបីអ្នកមានបញ្ហាកនុងការទទួលហានព័ត៌មានពីគមរាងរបស់យើងដាយសារបញ្ហាភាសា
ឬពិការភាពហើយអ្នកចង់ដាក់ពាកយបណ្តឹង សូមហៅទូរស័ព្ទមកកាន់ Medicare តាមរយៈលខេ 1-800-MEDICARE
(1-800-633-4227)។ អ្នកអាចទូរសព្ទមក 24 ម៉ាងកនុងមួយច្រងៃ 7 ច្រងៃកនែុងមួយសបតាហ៍។ អ្នកប្រើប្រាស់ TTY
សូមទូរសព្ទទៅលខេ 1-877-486-2048។ អ្នកក៏អាចដាក់ពាកយបណ្តឹងទៅកាន់ Medi-Cal ហានផងដរែ ដាយទូរសព្ទទៅ
Cal MediConnect Ombudsman តាមរយៈលខេ1-855-501-3077 ។ អ្នកប្រើប្រាស់ TTY សូមទូរសព្ទទៅលខេ 711។

A. حق شما برای دریافت اطلاعات به گونه‌ای که مطابق با نیازهای شما باشد

باید مزایای طرح و حقوق شما را به گونه‌ای در اختیار شما قرار دهیم که بتوانید آنها را درک کنید. باید هر سالی که در طرح ما هستید، حقوقتان را به شما خاطرنشان کنیم.

- برای دریافت اطلاعات به روشی که بتوانید آن را درک کنید، با بخش خدمات اعضا تماس بگیرید. طرح ما افرادی در اختیار دارد که به سؤالات به زبان‌های مختلف پاسخ می‌دهند.

- همچنین طرح ما می‌تواند مطالب را به زبان‌های اسپانیایی، ارمنی، کامبوج، چینی، فارسی، کره ای، روسی، تاگالوگ، ویتنامی، عربی و در قالب‌هایی مانند چاپ با قلم درشت، بریل یا صوتی ارائه کند. برای درخواست جهت دریافت مطالب به زبانی غیر از انگلیسی یا یک قالب دیگر در حال حاضر یا در آینده، لطفاً با بخش خدمات اعضاء به شماره711 :TTY ،665-4627 (855)، دوشنبه تا جمعه از 8 صبح تا 8 شب به وقت محلی تماس بگیرید.
- می توانید درخواست کنید که ما همیشه اطلاعات را به زبان یا قالبی که نیاز دارید برای شما ارسال کنیم. به این امر درخواست دائمی گفته می شود. ما حساب درخواست دائمی شما را نگه می داریم تا لازم نباشد که هر بار که برایتان اطلاعات ارسال می کنیم به طور جداگانه درخواست کنید. برای دریافت این نوشتار به زبانی به غیر از انگلیسی، لطفاً با ایالت به شماره :TTY ،541-5555 (800) 711، دوشنبه تا جمعه از 8 صبح تا 5 بعدازظهر به وقت محلی به منظور بروز رسانی پرونده خود به زبان دلخواه تماس بگیرید. برای دریافت این نوشتار در قالب متفاوت، لطفاً با بخش خدمات اعضا به شماره 711 :TTY ،665-4627 (855)، دوشنبه الی جمعه از 8 صبح تا 8 شب به وقت محلی تماس بگیرید. یک نماینده می تواند به شما در ایجاد یا تغییر درخواست دائمی کمک کند. همچنین می توانید با مدیر پرونده برای دریافت کمک و راهنمایی در مورد درخواست های دائمی تماس بگیرید.

اگر به خاطر مشکلات زبانی یا معلولیت، در دریافت اطلاعات از برنامه درمانی ما با مشکل مواجه هستید و می خواهید شکایتی را اقامه کنید، با Medicare به شماره (1-800-633-4227) 1-800-MEDICARE تماس بگیرید. می‌توانید در 24 ساعت شبانه روز، 7 روز هفته تماس بگیرید. کاربران TTY باید با شماره 1-877-486-2048تماس بگیرند. همچنین می‌توانید توسط تماس با Cal MediConnect Ombudsmanبه شماره 1-855-501-3077، شکایتی را تسلیم کنید. کاربران TTY باید با 711 تماس بگیرند.

A. Դուք իրավունք ունեք ստանալ տեղեկություններ այն եղանակով, որը համապատասխանում է ձեր կարիքներին

Մենք պարտավոր ենք հայտնել ձեզ պլանի ծառայությունների և ձեր իրավունքների մասին այն ձևով, որն ընկալելի է ձեզ համար: Մենք պետք է տեղեկացնենք ձեզ ձեր իրավունքների մասին յուրաքանչյուր տարի, երբ դուք գտնվում եք մեր պլանում:

- Ձեզ համար ընկալելի եղանակով տեղեկություն ստանալու համար, զանգահարեք Անդամակիցների սպասարկման բաժին: Մեր պլանում կան մասնագետներ, ովքեր կարող են պատասխանել հարցերին տարբեր լեզուներով:

- Մեր պլանը կարող է նաև տրամադրել նյութեր իսպաներեն, հայերեն, կամբոջերեն, չինարեն, ֆարսի, կորեերեն, ռուսերեն, թագալերեն, վիետնամերեն, արաբերեն լեզուներով և այնպիսի ձևաչափերով, ինչպիսիք են խոշոր տառատեսակը, Բրեյլի տառատեսակը կամ աուդիո ձևաչափը: Նյութերն անգլերենից բացի այլ լեզվով կամ այլընտրանքային ձևաչափով այժմ և հետագայում ստանալու նպատակով մշտական դիմում ներկայացնելու համար, խնդրում ենք դիմել Անդամակիցների սպասարկման բաժին՝ (855) 665-4627, TTY՝ 711, երկուշաբթիից ուրբաթ 8:00-ից 20:00 տեղական ժամանակով:

- Նյութերն անգլերենից բացի այլ լեզվով կամ այլընտրանքային ձևաչափով այժմ և հետագայում ստանալու նպատակով մշտական դիմում ներկայացնելու համար, խնդրում ենք դիմել Անդամակիցների սպասարկման բաժին՝ ‹include-if()(855) 665-4627, TTY՝ 711, երկուշաբթիից ուրբաթ 8:00-ից 20:00 տեղական ժամանակով:

- Կարող եք խնդրել, որ մենք միշտ ձեզ տեղեկատվություն ուղարկենք ձեզ անհրաժեշտ լեզվով կամ ձևաչափով: Դա կոչվում է մշտական պահանջ: Մենք կհետևենք ձեր մշտական պահանջին, այնպես որ ձեզ անհրաժեշտ չլինի առանձին հայցեր ներկայացնել յուրաքանչյուր անգամ, երբ մենք ձեզ տեղեկատվություն ենք ուղարկում: Այս փաստաթուղթը անգլերենից բացի այլ լեզվով ստանալու համար դիմեք Պետությանը հետևյալ հեռախոսահամարով՝ (800) 541-5555, TTY՝ 711, երկուշաբթիից ուրբաթ 8:00-ից 17:00-ը տեղական ժամանակով)՝ ձեր գրառումը նախընտրելի լեզվով թարմացնելու համար: Այս փաստաթուղթը այլընտրանքային ձևաչափով ստանալու համար խնդրում ենք կապվել Մասնակիցների սպասարկման բաժնի հետ (855) 665-4627, TTY՝ 711, Երկուշաբթիից-ուրբաթ, 8:00-20:00 տեղական ժամանակով: Ներկայացուցիչը կարող է օգնել ձեզ կատարել կամ փոխել մշտական պահանջը: Դուք կարող եք նաև կապ հաստատել ձեր Գործի մենեջերի հետ՝ մշտական հարցումների համար օգնություն ստանալու համար:

Եթե լեզվի հետ կապված խնդիրների կամ հաշմանդամության պատճառով դժվարանում եք մեր պլանից տեղեկություն ստանալ և ցանկանում եք բողոք ներկայացնել, զանգահարեք Medicare 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով: Դուք կարող եք զանգահարել շուրջօրյա, շաբաթը յոթ օր: TTY օգտվողները պետք է զանգահարեն 1-877-486-2048 հեռախոսահամարով: Դուք կարող եք նաև բողոք ներկայացնել Medi-Cal-ին՝ զանգահարելով Cal MediConnect Ombudsman-ին՝ 1-855-501-3077: TTY օգտվողները պետք է զանգահարեն 711:

B. Our responsibility for your timely access to covered services and drugs

If you have a hard time getting care, contact Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely service from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of your *Member Handbook*.

- You have the right to make your own healthcare decisions with help from your care team and Case Manager.

Chapter 9 of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you do not agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights to your information and to control how your PHI is used. We give you a written notice that tells you about these rights and explains how we protect the privacy of your PHI. The notice is called the “Notice of Privacy Practice.”

Members who may consent to receive sensitive services are not required to obtain any other member’s authorization to receive sensitive services or to submit a claim for sensitive services. Molina Medicare Complete Care Plus will direct communications regarding sensitive services to a member’s alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Molina Medicare Complete Care Plus will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Molina Medicare Complete Care Plus will accommodate requests for confidential communication in the form and format requested, if it is readily producible in the requested form and format, or at alternative locations. A member’s request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Expect for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You or someone legally authorized to make decisions for you can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law.

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if the changes should be made.

- You have the right to know if and how we shared your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

Your Privacy

Dear Molina Medicare Member:

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

PHI means protected health information. PHI includes your name, member number, race, ethnicity, language needs, or other things that identify you. Molina wants you to know how we use or share your PHI.

Why does Molina use or share our Members' PHI?

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

When does Molina need your written authorization (approval) to use or share your PHI? Molina needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

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

How does Molina protect your PHI?

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

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

What must Molina do by law?

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

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

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.

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

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. Our Notice of Privacy Practices is in the following section of this Member Handbook. It is on our web site at www.molinahealthcare.com. You may also get a copy of our Notice of Privacy Practices by calling our Member Services Department at (855) 665-4627, 7 days a week, 8 a.m. to 8 p.m. local time. TTY users, please call 711.

NOTICE OF PRIVACY PRACTICES

MOLINA HEALTHCARE OF CALIFORNIA

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 California ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") uses and shares protected health information about you to provide your health benefits as a Medicare Complete Care Plus (HMO D-SNP) 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 September 23, 2013.

PHI means protected health information. PHI is health information that includes your name, Member number or other identifiers, and is 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;
- Address 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?

In addition to treatment, payment and health care operations, 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, such as when approved by a privacy or institutional review board.

Legal or Administrative Proceedings

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

Law Enforcement

Your PHI may be used or shared with police for law enforcement purposes, such as 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, such as national security activities.

Victims of Abuse, Neglect or Domestic Violence

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

Workers Compensation

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

Other Disclosures

Your PHI may be shared with funeral directors or coroners to help them to 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 confidential communications requests to provide PHI in a particular form or format, if it is readily producible in the requested form and format, or at alternative locations. You will need to make your request in writing or by electronic transmission.

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;
- 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; or
- as part of a limited data set in accordance with applicable law; or
- PHI released in the interest of national security or for intelligence purposes.

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 request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Molina Member Services at (855) 665-4627, 7 days a week, 8 a.m. to 8 p.m. local time. TTY users, please call 711.

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:
Molina Healthcare of California
Attention: Manager of Member Services
200 Oceangate, Suite 100 Long Beach, CA 90802

Phone: (855) 665-4627, 7 days a week, 8 a.m. to 8 p.m. local time. TTY users, call 711.

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

U.S. Department of Health & Human Services
Office for Civil Rights - Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 509F, HHH Building
Washington, D.C. 20201

(800) 368-1019; (800) 537-7697 (TTY);

(202) 619-3818 (FAX)

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.

Contact Information

If you have any questions, please contact the following office:
By Phone:
Molina Member Services
(855) 665-4627, TTY: 711., 7 days a week, 8:00 a.m. to 8:00 p.m., local time.
In Writing:
Molina Healthcare of California
Attention:
Medicare Appeals and Grievances
P.O. Box 22816
Long Beach, CA 90801

This information is available for free in other languages. Please call our customer service number at (855) 665-4627, TTY 711, 7 days a week, 8 a.m. - 8 p.m., local time. Esta información está disponible gratuitamente en otros idiomas. Por favor, comuníquese a nuestro número de teléfono para servicio al cliente al (855) 665-4627,TTY 711, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., hora local.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you do not speak English, we have interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time. This is a free service to you. We can also give you written materials and/or information in Spanish, Armenian, Arabic, Vietnamese, Khmer, Chinese, Russian, Farsi, Tagalog, and Korean. We can also give you information in large print, braille, or audio. To make a standing request to get materials in a language other than English or in an alternate format now and in the future, please contact Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:

- how to choose or change primary care providers
- qualifications of our network providers and pharmacies
- how we pay providers in our network

- Covered services and drugs and about rules you must follow, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook)* covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of you *Member Handboo*k.

F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another Medicare Advantage plan.
- Refer to **Chapter 10** of your *Member Handbook:*
  - For more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
  - For information about how you will get your Medi-Cal benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about different of treatment options.

- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. Chapter 9 of your *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen

For more information, call Molina Medicare Complete Care Plus (HMO D-SNP) Member Services toll-free at (855) 665-4627, 7 days a week, 8 a.m. to 8 p.m., local time. If you are deaf or hard of hearing, call TTY: 711 for the California Relay Service

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do not want.

The legal document that you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
  - The hospital will ask you if you have signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Molina Medicare Complete Care Plus (HMO D-SNP) will tell you about changes to the state law no later than 90 days after the change.

Having an advance directive is your choice. Call Member Services for more information.

G3. What to do if your instructions are not followed

If you signed an advance directive, and you think that a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Ombuds Program.

Ombuds Program 1-855-501-3077. This call is free.

TTY: 1-855-847-7914. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Write: **Department of Health Care Services**
1501 Capitol Avenue
PO Box 997413
Sacramento, Ca 95814

Website: https://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx

H. Your right to make complaints and ask us reconsider our decisions

Chapter 9 of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly - and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* — or you want more information about your rights, you can call:

- Member Services at at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.
- The Health Insurance Counseling and Advocacy Program (HICAP) program at 1-800-434-0222. For more details about HICAP, refer to **Chapter 2**.
  - Los Angeles county : (213) 383-4519
  - San Diego county: (858) 565-8772
  - Imperial county: (760) 353- 0223
  - Riverside and San Bernardino county: (909) 256-8369
- The Ombuds Program at 1-888-452-8609. For more details about this program and how to contact it, refer to **Chapter 2** of your *Member Handbook.*

- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*.Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your Case Manager** including completing an annual health risk assessment.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor’s office, hospitals, and with other providers.
- **Tell us about any services you receive outside of our plan.**
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most plan members, Medi-Cal pays for your Part A premium and your Part B premium.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.**
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells you about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.

  - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and Medi-Cal.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have a new phone number** or a better way to contact you.
- Call Member Services for help if you have questions or concerns.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include Community-Based Adult Services (CBAS), and Nursing Facility (NF) services.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are have a problem with your care, you can call the Ombuds Program at 1-888-452-8609 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of your *Member Handbook*.

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints;** also called grievances. To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-434-0222.

Help from the Health Consumer Alliance

You can call the Health Consumer Alliance and speak with an advocate about your health coverage questions. They offer free legal help. The Health Consumer Alliance is not connected with us or with any insurance company or health plan. Their phone number is 1-888-804-3536 and their website is www.healthconsumer.org.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: user call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from Medi-Cal

Call: (916) 449-5000, Monday - Friday, 8:00 a.m. - 5:00p.m., local time.

TTY: 711

Help from the California Department of Health Care Services

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is **1-888-466-2219**. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free **TDD** number, **1-877-688-9891**.

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 (855) 665-4627 TTY: 711, 7 days a week, 8:00 a.m. to 8:00 p.m., local time 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 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."

C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to **all** of your Medicare and Medi-Cal benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care, or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.	
Yes. My problem is about benefits or coverage. Refer to **Section E: "Coverage decisions and appeals"** on page 155.	**No.** My problem is not about benefits or coverage. Refer to **Section K: "How to make a complaint"** on page 186.

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be ensure whether we cover specific medical service or drug.

If we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

In most cases, you must start your appeal at Level 1. If you do not want to first appeal to the plan for a Medi-Cal service, if your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an Independent

Medical Review from the Department of Managed Health Care at www.dmhc.ca.gov. Refer to page 153 for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say **No** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. An Independent Review Organization that is not connected to us conducts the Level 2 Appeal.

- In some situations, your case is **automatically sent** to the Independent Review Organization for a Level 2 Appeal. If this happens, we tell you.
- In other situations, you **need to ask** for a Level 2 Appeal.
- Refer to **Section F4** for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time.
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care** (DMHC) for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is **1-888-466-2219**. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free **TDD** number, **1-877-688-9891.**
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
  - Ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.
- Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you. Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.MolinaHealthcare.com/Medicare. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to **the section that applies:**

- **Section F**, “Medical care”
- **Section G**, “Medicare Part D prescription drugs”
- **Section H**, “Asking us to cover a longer hospital stay”
- **Section I**, “Asking us to continue covering certain medical services (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Member Services at the numbers at the bottom of the page.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are usually drugs administered by your doctor or health care professional.. Different rules may apply to a Part B prescription drug. When they do, we explain how rules for Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3.**

3. You got medical care that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5.**

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5.**

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

6. You are experiencing delays in care or you cannot find a doctor.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4.**

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision" involves your medical care, it's called an "**integrated organization determination**."

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time
- Faxing: (844) 834-2155.
- Writing: Attn: Medicare Member Services 200 Oceangate Ste. 100 Long Beach, CA 90802.

We will decide routine pre-approvals within 5 business days of when we get the information needed to make a decision, and no later than 14 calendar days after receiving the request.

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 5 business days of when we get the information needed to make a decision, and no later than 14 calendar days after receiving the request.
- Medicare Part B prescription drug within 72 hours after we get your request.

For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

> The legal term for "fast coverage decision" is "**expedited determination**."

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. (You can't ask for a fast coverage decision about payment for medical care you already got.)
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give youa fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor’s support, we decide if you get a fast coverage decision.

If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

- We automatically give you a fast coverage decision if your doctor asks for it
- How you can file a “fast complaint” about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (**refer to Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won’t review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn’t legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor or your representative must contact us. Call us at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time. For additional details on how to reach us for appeals, refer to **Chapter 2**.

Ask for a "standard appeal" or a "fast appeal" in writing or by calling us at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you ,include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at www.MolinaHealthcare.com/Medicare.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

We will send you a letter within 5 calendar days of receiving your appeal letting you know that we received it.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is "**expedited reconsideration**."

- If you appeal a decision we made about coverage for care that you did not get, you and/ or your doctor decide if you need a fast appeal.
- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2**.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal **within 10 calendar days** of the date on our letter or by the intended effective date of the action, whichever is later.

- If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
- You will also get all other services or items (that are not the subject of your appeal) with no changes.
- If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.

If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

- If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say No to part or all of your request, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.

If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say No to part or all of your request, you have additional appeal rights:

If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service or item that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits for the service or item. You must make the request on or before the later of the following in order to continue your benefits:

- Within 10 days of the mailing date of our notice of action; or
- The intended effective date of the action

If you meet this deadline, you can keep getting the disputed service or item while your appeal is processing.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if the Medicare or Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item, that **Medicare** usually covers we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item, that **Medi-Cal** usually covers you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.

- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **If the Independent Review Organization says Yes to part or all of a request for a medical item or service,** we must promptly implement the decision:
  - Authorize the medical care coverage **within 72 hours** or
  - Provide the service within **14 calendar days** after we get the Independent Review Organization's decision for **standard requests** or
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- If the Independent Review Organization says **Yes** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests** or
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests.**
- If the Independent Review Organization says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If your case meets the requirements, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2, for a total of five levels.

If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.

An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Go to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medi-Cal usually covers

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

(1) Independent Medical Review

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by doctors who are not part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it is not medically necessary.
- Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Will not pay for emergency or urgent Medi-Cal services that you already received.
- Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours for a fast appeal.

NOTE: If your provider filed an appeal for you, but we do not get your Appointment of Representative form, you will need to refile your appeal with us before you can file for a Level 2 IMR with the Department of Managed Health Care.

You are entitled to both an IMR and a State Hearing, but not if you have already had a State Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. Refer to page 175 for information, about our Level 1 appeal process. If you disagree with our decision, you can file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

If your treatment was denied because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.

You must **apply for an IMR within 6 months** after we send you a written decision about your appeal. The DMHC may accept your application after 6 months for good reason, such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice from us of the IMR process.

To ask for an IMR:

- Fill out the Independent Medical Review Application/Complaint Form available at: www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx or call the DMHC Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.

- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- Mail or fax your forms and any attachments to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
FAX: 916-255-5241

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case is not eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

(2) State Hearing

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the "Your Hearing Rights" notice is mailed to you.

NOTE: If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read "Will my benefits continue during Level 2 appeals" on page 177 for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:

- To the county welfare department at the address shown on the notice.

- To the California Department of Social Services:

  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, California 94244-2430

- To the State Hearings Division at fax number 916-651-5210 or 916-651-2789.

2. You can call the California Department of Social Services at 1-800-952-5253. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for drug categories that require a copay.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to payback or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you or your provider the payment or if the plan has cost sharing, our share of the cost for the service or item within 60 calendar days after we get your request. Your provider will then send the payment to you.

- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item, and explaining why.

If you don't agree with our decision not to pay **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision." or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information on additional levels of appeal.

If our answer to your appeal is **No** and **Medi-Cal** usually covers the service or item, you can file a Level 2 Appeal yourself (We do not automatically file a level 2 appeal for you. Refer to **Section F4** for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are Medicare "Part D drugs." There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Part D drug appeals.**

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

G1. Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including asking us to
  - Cover a Part D drug that is not on Our plan's Drug List or
  - Set aside a restriction on our plan's coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as, when your drug is on our plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription can't be filled, as written, the pharmacy gives you a notice explaining how to contact us to ask for a coverage decision.

> An initial for a coverage decision about your Part D drugs is called a "**coverage determination**."

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions **and** how to make an appeal.

Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover. **You can ask us to make an exception.** (This is a type of coverage decision.) Start with **Section G2**, then refer to **Sections G3 and G4**	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need? **You can ask us for a coverage decision.** Refer to **Section G4**	You want to ask us to pay you back for a drug you already got and paid for. **You can ask us to pay you back.** (This is a type of coverage decision.) Refer to **Section G4**	We told you that we won't cover or pay for a drug in the way that you want. **You can make an appeal.** (This means you are asking us to reconsider.) Refer to **Section G5**

G2. Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List.**

- If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies to drugs in tier 4.
- You can't get an exception to the required copay amount for the drug.

2. **Removing a restriction for a covered drug**.

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we will agree to cover the drug for you. This is sometimes called "prior authorization."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. **Changing coverage of a drug to a lower cost-sharing tier**. Every drug on our Drug List is in one of cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

> Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a "**formulary exception**."

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

G3. Important things to know about asking an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do not approve your exception request.

We can say Yes or No to your request

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision including an exception

- Ask for the type of coverage decision you want by calling (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a “supporting statement.” The supporting statement includes your doctor or other prescriber's medical reasons for the exception.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can tell us by phone, and then fax or mail the statement.

If your health requires it, ask for a “fast coverage decision before”

We use the “standard deadlines” unless we agree to use the “fast deadlines.”

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor’s statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor’s statement.

> A “fast coverage decision” is called an **“expedited coverage determination.”**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We will give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say is **No** to part or all of your request we send you a letter. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer with in 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard or fast appeal** by calling (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information regarding your claim.
- You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a "fast appeal"

A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get you and your doctor or other prescriber decide if you need a "fast appeal."
- Requirements for a "fast appeal" are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get. ask for a “fast appeal.”
- We give you our decision sooner if you didn’t get the drug and your health condition requires it,

If we do not give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If our answer is Yes to part or all of you request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If our answer is No to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.

If we don’t give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to you Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 appeals process. The Independent Review **Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the “Independent Review Organization” is the **“Independent Review Entity,”** sometimes called the **“IRE.”**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization in writing and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.

- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your "case file." **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the Independent Review Organization.

Deadlines for a fast appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of what you asked for, we must provide the approved drug coverage **within 24 hours** after the Independent Review Organization's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer.

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.

If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information you need it.

You can at a copy of this notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In California, the Quality Improvement Organization is Livanta. Call them at: (877) 588-1123, TTY: (855) 887-6668. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section F4 on page 162 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

> The legal term for **“fast review”** is “**immediate review**” or **“expedited review”**

What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement but you may.
- Reviewers will look at your medical information talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you will get another notice that explains why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> **The legal term** for this written explanation is the “**Detailed Notice of Discharge**.” You can get a sample by calling Member Services at the numbers are the bottom of the page or

1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You may have to pay the full cost of the hospital care you get after at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at (877) 588-1123, TTY: (855) 887-6668.

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for our share of hospital care you got since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section F4 on page 162 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review” of your hospital discharge date.

> The legal term for “fast review” or “fast appeal” is **“expedited appeal.”**

- We look at all of the information about your hospital stay.
- We check that if the first decision was fair and followed the rules.
- We use fast deadlines instead of the standard deadlines and give you our decision within 72 hours you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as it is medically necessary.
- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any share of the costs after this date.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section J** for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours..

If the Independent Review Organization says **Yes** to your appeal:

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section F4 on page 162 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that service ends, we will stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage". The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it**. If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.
- **Contact the Quality Improvement Organization**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a fast track appeal.** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.
- If the Quality Improvement Organization will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section F4 on page 162 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

The legal term for the written notice is "**Notice of Medicare Non-Coverage**."To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

What happens during a fast track appeal

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.

- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is "**Detailed Explanation of Non-Coverage**."

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at (877) 588-1123; TTY: (855) 887-6668.

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue with the appeal process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section F4 on page 162 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Will my benefits continue during Level 2 appeals?

If your problem is about a service or item covered by Medicare, your benefits for that service or item will not continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service or item covered by Medi-Cal and you ask for a State Hearing, your Medi-Cal benefits for that service or item can continue until a hearing decision is made. You must ask for a hearing on or before the later of the following in order to continue your benefits:

- Within 10 days of the mailing date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld; or
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item until the hearing decision is made.

I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

> The legal term for “fast review” or “fast appeal” is **“expedited appeal.”**

- We look at all of the information about your case.
- We check that the first decision was fair and followed all the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours after you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree you need services longer.
- We agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- Our coverage for these services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal, we send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline or other deadlines, you can make a complaint. Refer to **Section K** for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section F4 on page 162 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

If you do not agree with the State Hearing decision and you want another judge to review it, you may ask for a rehearing and/or seek judicial review. To ask for a rehearing, mail a written request (a letter) to:

The Rehearing Unit
744 P Street, MS 19-37
Sacramento, CA 95814

This letter must be sent within 30 days after you get your decision. This deadline can be extended up to 180 days if you have a good reason for being late.

In your rehearing request, state the date you got your decision and why a rehearing should be granted. If you want to present additional evidence, describe the additional evidence and explain why it was not introduced before and how it would change the decision. You may contact legal services for assistance.

To ask for judicial review, you must file a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after receiving your decision. File your petition in the Superior Court for the county named in your decision. You may file this petition without asking for a rehearing. No filing fees are required. You may be entitled to reasonable attorney's fees and costs if the Court issues a final decision in your favor.

If a rehearing was heard and you do not agree with the decision from the rehearing, you may seek judicial review but you cannot request another rehearing.

J3. Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal
Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide to **accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.

Complaint	Example
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the Independent Review Organization on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call (855) 665-4627, TTY: 711,
7 days a week, 8 a.m. – 8 p.m., local time.

The legal term for a "complaint" is a "**grievance**."

The legal term for "making a complaint" is "**filing a grievance**."

K2. Internal complaints

To make an internal complaint, call Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8 a.m. – 8 p.m., local time. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- We will answer your complaint as quickly as your health requires and no later than 30 days after we receive it. If you file a complaint, we will send you a letter within 5 calendar days of receiving your appeal letting you know that we received it. If you call us with your complaint, we will call you or send you a letter with our response. If you write to us, we will send you a letter with our answer. You can call us at (800) 665-0898, TTY: 711, 7 days a week, 8:00 a.m. to 8:00 p.m., local time; or write to us at Molina Medicare Complete Care Plus Appeals and Grievances,PO Box 22816, Long Beach, CA 90801, Fax: (562) 499-0610.

> **The legal term** for “fast complaint” is “**expedited grievance**.”

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If we don't **agree** with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

You do not need to file a complaint with Molina Medicare Complete Care Plus before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

Medi-Cal

You can file a complaint with the California Department of health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. You may contact the DMHC if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you are in severe

pain, if you disagree with our plan's decision about your complaint, or if our plan has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

Office for Civil Rights

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:
(877) 588-1123,
Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time), 24 hour voicemail is available.
TTY:(855) 887-6668
https://www.livantaqio.com/en/states/california

You may also have rights under the Americans with Disability Act and under any applicable state law. You can contact.

Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook*.

In California, the Quality Improvement Organization is called Livanta. The phone number for Livanta is (877) 588-1123, TTY: (855) 887-6668.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. When you can end your membership with our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods each year:**

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period,** which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage Open Enrollment Period,** which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for Medi-Cal or Extra Help changed, or
- If you recently moved into, currently are getting care in, or just moved out of in a nursing home or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**
- Medi-Cal services in **Section C**

You can get more information about how you can end your membership by calling:

- Member Services at the numbers at the bottom of the page.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.
- Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-8000-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8:00 a.m. to 5:00 p.m or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

NOTE: If you're in a drug management program, you may not be able to change plans. Refer to **Chapter 5** of your *Member Handbook* for information about drug management programs.

B. How to end your membership in our plan

You have the following options if you want to leave our plan:

- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users should call 1-800-430-7077; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart below.
- Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.
- Unless you have moved out of your county, your Medi-Cal membership will continue with Molina Medicare Complete Care Plus.

C. How to get Medicare and Medi-Cal services

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another Medicare health plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For PACE inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/ . **OR** Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan may change.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/ . **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage or call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/ . You are automatically disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

D. How to get your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Molina Medicare Complete Care Plus ends, our plan will cover your hospital stay until you are discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is only for people who qualify for both Medicare and Medi-Cal.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan’s service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your plan ID card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. You think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your Member Handbook.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Member Handbook*. The main laws that apply are federal and state laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Medi-Cal must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medial condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call the Department of Health Care Services, Office for Civil Rights at 916-440-7370. TTY users can call 711 (Telecommunications Relay Service).
- Send an email to CivilRights@dhcs.ca.gov.
- Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Complaint forms are available at:

  www.dhcs.ca.gov/Pages/Language_Access.aspx

If you believe that you have been discriminated against and want to file a discrimination grievance, contact Member Services at (855) 665-4627 TTY: 711.

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

- By phone: Call 916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care plan: Refer to "Individualized Care Plan."

Care Plan Optional Services (CPO Services): Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to get under Medi-Cal.

Care team: Refer to "Interdisciplinary Care Team."

Case Manager: Molina employee who works with you, the health plan, and with your care providers to make sure you get the care you need.

Catastrophic coverage stage: The stage in the Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you reach the $7,400.00 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

Community-Based Adult Services (CBAS): Outpatient, facility based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Department of Health Care Services (DHCS): The state department in California that administers the Medicaid Program known as Medi-Cal.

Department of Managed Health Care (DMHC): The state department in California that is responsible for regulating health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of five (5) tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health Insurance Counseling and Advocacy Program (HICAP): A program that provides free and objective information and counseling about Medicare. **Chapter 2** of your *Member Handbook* explains how to contact HICAP.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Case Managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment: A review of a your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Independent Medical Review (IMR): If we deny your request for medical services or treatment, you can make an appeal. If you disagree with our decision and your problem is about a Medi-Cal service, including DME supplies and drugs, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by doctors who are not part of our plan. If the IMR decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

Independent Physician Association (IPA): An IPA is a company contracted by Molina Medicare Complete Care Plus (HMOD-SNP) that organizes a group of doctors, specialists, and other providers of health services to see Molina Medicare Complete Care Plus. Your doctor, along with the IPA, takes

care of all your medical needs. This includes getting authorization, if it is required, to see specialist doctors or receive medical services such as lab tests, x-rays, and inpatient and outpatient hospital services.

Individualized Care Plan (ICP or Care Plan): A care plan includes your main health concern, goals, needs and services you may need. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient or receiving observation services instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may includes your Primary Care Physician, Case Manager, may include other specialty care providers. Caregiver, or other health professionals who are there to help you get the care you need. Your care team also helps make or update your care plan.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital. LTSS include Community Based Adult Services (CBAS), and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help."

Mail Order Program: Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

Medi-Cal: This is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government.

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to **Chapter 2** of your *Member Handbook* for information about how to contact Medi-Cal.

Medi-Cal plans: Plans that cover only Medi-Cal benefits, such as long term services and supports, medical equipment, and transportation. Medicare benefits are separate.

Medically necessary: This describes the needed services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Medi-Cal coverage rules.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA" that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Part B.

Medicare-Medi-Cal enrollee: A person who qualifies for Medicare and Medi-Cal coverage. A Medicare-Medi-Cal enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA" that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medi-Cal. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Part D. Medi-Cal may cover some of these drugs.

Medication Therapy Management: A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your Member Handbook for more information.

Member (member of our plan, or plan member): A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, and accept our payment, and do not charge members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of its providers, make a decision about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of your *Member Handbook* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you see any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

Prior authorization: A Service Request that is submitted by your PCP in order to get approval or authorization for a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets prior authorization from us.

- Covered services that need our plan's prior authorization are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get prior authorization from us.

- Covered drugs that need our plan's prior authorization are marked in the List of Covered Drugs.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medi-Cal benefits together for people age 55 and older who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider. that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Referral: A referral is your primary care provider's(PCP's) approval to can use a provider other than your PCP. If you don't get approval, first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook*. to learn more about rehabilitation services.

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care and intimate partner violence.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, It's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Specialized pharmacy: Refer to **Chapter 5** of your *Member Handbook* to learn more about specialized pharmacies.

State Hearing: If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits. SSI automatically provides Medi-Cal coverage.

Urgent care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Molina Medicare Complete Care Plus (HMO D-SNP) Member Services

Method	Contact Information
CALL	(855) 665-4627 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. local time Member Services also has free language interpreter services available for non-English speakers. We have free interpreter services for people who do not speak English.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	For Medical Services: Attn: Medicare Member Services For Part D (Rx) Services: Fax: (866) 290-1309
WRITE	**For Medical Services:** 200 Oceangate Suite 100 Long Beach, CA 90802 **For Part D (Rx) Services:** 7050 Union Park Center Suite 200 Midvale, UT 84047
WEBSITE	www.MolinaHealthcare.com/Medicare