2023 Annual Notice of Changes

Molina Medicare Complete Care (HMO D-SNP)

California H5810_001

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 (HMO D-SNP) offered by Molina Healthcare of California

Annual Notice of Changes for 2023

You are currently enrolled as a member of Molina Medicare Complete Care (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage,* which is located on our website at www.MolinaHealthcare.com/Medicare

You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Molina Medicare Complete Care (HMO D-SNP).

- To **change to a different plan**, you can switch plans between October 15 and December 7.Your new coverage will start on **January 1, 2023.** This will end your enrollment with Molina Medicare Complete Care.
- Look in section 2 , page 12 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at (800) 665-0898 for additional information. (TTY users should call 711.) Hours are from 7 days a week, 8:00 a.m. to 8:00 p.m., local time.
- You can get this document for free in non-English language(s) or other formats, such as large print, braille, or audio. Call (800) 665-0898, (TTY:711). The call is free.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Molina Medicare Complete Care (HMO D-SNP)

- Molina Healthcare is an HMO D-SNP Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment depends on contract renewal.
- When this document says "we," "us," or "our," it means Molina Healthcare of California When it says "plan" or "our plan," it means Molina Medicare Complete Care (HMO D-SNP).
- Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Molina Medicare Complete Care (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays	$0 copay The plan covers up to 90 days of inpatient hospital care each benefit period. You also have an additional 60 days of coverage, called lifetime reserve days. These 60 days can be used only once. We will automatically start applying lifetime reserve days unless you specifically tell us not to. (refer to your Evidence of Coverage for more detail on benefit periods)	$0 copay The plan covers up to 90 days of inpatient hospital care each benefit period. You also have an additional 60 days of coverage, called lifetime reserve days. These 60 days can be used only once. We will automatically start applying lifetime reserve days unless you specifically tell us not to. (refer to your Evidence of Coverage for more detail on benefit periods)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay

Cost	2022 (this year)	2023 (next year)
	• Drug Tier 2: $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription • Drug Tier 3: $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription • Drug Tier 4: $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription • Drug Tier 5: $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription	• Drug Tier 2: $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 • Drug Tier 3: $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 • Drug Tier 4: $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 • Drug Tier 5: $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	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$7,550 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,300 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum	$7,550	$8,300 Once you have paid $8,300 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services

Cost	2022 (this year)	2023 (next year)
out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.MolinaHealthcare.com/Medicare. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
In-Home Support Services	In-Home Support Services is not covered.	You pay a $0 copay for up to 90 hours of In-Home Support Services.

Cost	2022 (this year)	2023 (next year)
Dental services (Supplemental)	You have a $1,000 maximum allowance each calendar year for all supplemental comprehensive dental services, including dentures.	You have a $1,600 maximum allowance each calendar year for all supplemental comprehensive dental services, including dentures.
Special Supplemental Benefits for the Chronically Ill (SSBCI)- Food and produce	$35 allowance every month for healthy food and produce. Upon approval, your MyChoice Card will be loaded with your allowance to access your benefit. Eligible members receive a debit card with an allowance every month to obtain healthy produce and groceries, unused allowance does not carry over to next month. Allowance expires at the end of the calendar year. Members who have the following chronic conditions are eligible: Cancer, Cardiovascular disorders, Chronic heart failure, Diabetes, Chronic lung disorders, and Stroke.	$55 allowance every month for healthy food and produce. Upon approval, your MyChoice Card will be loaded with your allowance to access your benefit. Eligible members receive a debit card with an allowance every month to obtain healthy produce and groceries, unused allowance does not carry over to next month. Allowance expires at the end of the calendar year. Members who have the following chronic conditions are eligible: 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; and Stroke.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

• Getting Help from Medicare – If you chose this plan because you were looking for insulin coverage at $35 or less a month, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

• **Additional Resources to Help –** Please contact our Member Services number at (800) 665-0898 for additional information. (TTY users should call 711.) Hours are 7 days a week, 8:00 a.m. to 8:00 p.m., local time.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Preferred Generic - Tier 1:*** You pay a $0 copay per prescription ***Generic - Tier 2:*** You pay a $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription ***Preferred Brand - Tier 3:*** You pay a $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription ***Non-Preferred Drug - Tier 4:***	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Preferred Generic - Tier 1:*** You pay a $0 copay per prescription ***Generic - Tier 2:*** You pay a $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 ***Preferred Brand - Tier 3:*** You pay a $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 ***Non-Preferred Drug - Tier 4:***

Stage	2022 (this year)	2023 (next year)
	You pay a $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription ***Specialty Tier - Tier 5:*** You pay a $0, $1.35, or $3.95 copay for generic drugs (including brand drugs treated as generic) $0, $4.00, or $9.85 copay for all other drugs per prescription	You pay a $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 ***Specialty Tier - Tier 5:*** You pay a $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
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Molina Medicare Complete Care (HMO D-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Molina Medicare Complete Care.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Molina Medicare Complete Care (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Molina Medicare Complete Care (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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 have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called HICAP.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at
Los Angeles county: (213) 383-4519
San Diego county: (858) 565-8772
Riverside and San Bernardino county: (909) 256-8369
You can learn more about HICAP by visiting their website (http://www.cahealthadvocates.org/HICAP/).

For questions about your Medicaid benefits, contact California Department of Health Care Services at (916) 449-5000, TTY: 711, Monday - Friday, 8:00 a.m. - 5:00 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Office of AIDS. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (916) 449-5900.

SECTION 6 Questions?

Section 6.1 – Getting Help from Molina Medicare Complete Care (HMO D-SNP)

Questions? We're here to help. Please call Member Services at (800) 665-0898. (TTY only, call 711.) We are available for phone calls 7 days a week, 8:00 a.m. to 8:00 p.m., local time. Calls to these numbers are free.

Read your 2023 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the 2023 *Evidence of Coverage* for Molina Medicare Complete Care (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.MolinaHealthcare.com/Medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.MolinaHealthcare.com/Medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can 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 the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality STAR Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call California Department of Health Care Services at (916) 449-5000. TTY users should call TTY: 711.

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