



Molina Dual Options MI Health Link

Medicare-Medicaid Plan

2020 | Member Handbook

Michigan H7844-001
Serving Wayne and Macomb Counties



Molina Dual Options MI Health Link Medicare-Medicaid Plan *Member Handbook*

01/01/2020 – 12/31/2020

Your Health and Drug Coverage under the Molina Dual Options Medicare- Medicaid Plan

Member Handbook Introduction

This handbook tells you about your coverage under Molina Dual Options through 12/31/2020. It explains health care services, behavioral health coverage, prescription drug coverage, and long term supports and services. Long term supports and services 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. Please keep it in a safe place.

This plan is offered by Molina Healthcare of Michigan. When this *Member Handbook* says “we,” “us,” or “our,” it means Molina Healthcare of Michigan. When it says “the plan” or “our plan,” it means Molina Dual Options.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. The call is free.

ATENCIÓN: Si usted habla español, los servicios de asistencia del idioma, sin costo, están disponibles para usted. Llame al (855) 735-5604, servicio TTY al 711, de lunes a viernes, de 8:00 a. m. a 8:00 p.m., EST. La llamada es gratuita.

انتباه: كنت تتحدث اللغة العربية، نوفر لك خدمات المساعدة اللغوية المجانية. اتصل على (855) 735-5604 ، لمستخدمي أجهزة الهواتف النصية / أجهزة اتصالات المعاقين: 711، من الاثنين إلى الجمعة، من 8 صباحًا إلى 8 مساءً، بالتوقيت الشرقي. هذه المكالمات مجانية.

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) 642-3195, TTY: 711, Monday – Friday, 8 a.m. to 7 p.m., EST to update your record with the preferred language. To get this document in an alternate format, please contact Member Services at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. A representative can help you make or change a standing request. You can also contact your Care Coordinator for help with standing requests

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit

www.MolinaHealthcare.com/Duals.



2020 Molina Dual Options MI Health Link

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Disclaimers

- ❖ Molina Dual Options MI Health Link Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.
- ❖ Coverage under Molina Dual Options 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.



Chapter 1: Getting started as a member

Introduction

This chapter includes information about Molina Dual Options, a health plan that covers all your Medicare and Michigan Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from Molina Dual Options. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Welcome to Molina Dual Options

Molina Dual Options is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has Care Coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Molina Dual Options was approved by the State of Michigan and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MI Health Link program.

MI Health Link is a program jointly run by Michigan and the federal government to provide better health care for people who have both Medicare and Michigan Medicaid. Under this program, the state and federal government want to test new ways to improve how you get your Medicare and Michigan Medicaid health care services.

When C. David Molina, MD, founded Molina Healthcare in 1980, he had the simple mission to provide accessible healthcare services to families who needed it the most. Molina Dual Options is proud to carry this mission forward, committed to ensuring our enrollees have quality health care services.

B. Information about Medicare and Michigan Medicaid

B1. Medicare

Medicare is the federal health insurance program for the following people:

- 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. Michigan Medicaid

Michigan Medicaid is a program run by the federal government and the State of Michigan that helps people with limited incomes and resources pay for long term supports and services and medical costs. It also covers extra services and drugs not covered by Medicare. Each state has its own Medicaid program.

This means that each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, and
- the cost for services.

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

Medicare and the State of Michigan must approve Molina Dual Options each year. You can get Medicare and Michigan Medicaid services through our plan as long as:

- you are eligible to participate,

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- we choose to offer the plan, and
- Medicare and the State of Michigan approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Michigan Medicaid services will not be affected.

C. Advantages of this plan

You will now get all your covered Medicare and Michigan Medicaid services from Molina Dual Options, including prescription drugs. **You do not pay extra to join this health plan.**

Molina Dual Options will help make your Medicare and Michigan Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with one health plan for **all** of your health insurance needs.
- You will not pay a deductible or copay when you get services from a provider or pharmacy in our health plan's provider network. (You will be required to keep paying any monthly Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.)
- You will have your own Care Coordinator who will ask you about your health care needs and choices and work with you to create a personal care plan based on your goals.
- Your Care Coordinator will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve.
- If you qualify, you will have access to home and community-based supports and services to help you live independently.
- You have access to many health and disease management programs provided by Molina Dual Options.

D. Molina Dual Options' service area

Our service area includes these counties in Michigan: Macomb and Wayne counties. Only people who live in our service area can get Molina Dual Options.

If you move outside of our service area, you cannot stay in this plan. See 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 the following are true:

- you live in our service area, **and**
- you have Medicare Part A, Part B, and Part D, **and**
- you are eligible for full Michigan Medicaid benefits, **and**

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- you are a United States citizen or are lawfully present in the United States, **and**
- you are not already enrolled in hospice, **and**
 - to learn more about the hospice benefit please look at Chapter 4 of the Member Handbook
- you are not enrolled in the MI Choice waiver program or the Program of All-inclusive Care for the Elderly (PACE). If you are enrolled in either of these programs, you need to disenroll before enrolling in the MI Health Link program through Molina Dual Options.

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

You will get a Level I Assessment within the first 60 days of joining our plan. Your Care Coordinator will contact you and help you get this done. This assessment is very important. If you have any questions before your Care Coordinator contacts you, please call Molina Dual Options Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. **If Molina Dual Options is new for you**, you can keep getting services and seeing the doctors and other providers you go to now for at least 90 days from your enrollment start date.

If you get services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the Prepaid Inpatient Health Plan (PIHP), you will be able to get services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time period if your current provider is not part of Molina Dual Options' provider network. Call Molina Dual Options for information about nursing home services.

After 90 days, or after 180 days if you are getting services through the Habilitation Supports Waiver or the Managed Specialty Services and Supports Program through the PIHP, you will need to see doctors and other providers in the Molina Dual Options network. A network provider is a provider who works with the health plan. See Chapter 3 for more information on getting care.

G. Your care plan

Your care plan is the plan for what supports and services you will get and how you will get them.

After your Level I Assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make a care plan.

Every year, your care team will work with you to update your care plan if the health services you need and want change.

H. Molina Dual Options' monthly plan premium

Molina Dual Options does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at (855) 735-5604. You can also see the *Member Handbook* at www.MolinaHealthcare.com/Duals or download it from this website.

The contract is in effect for the months you are enrolled in Molina Dual Options between 01/01/2020 and 12/31/2020.


J. Other information you will get from us

You should have already gotten a Molina Dual Options 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 Molina Dual Options' Member ID Card

Under our plan, you will have one card for your Medicare and Michigan Medicaid services, including long term supports and services and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:

If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

	
<p>Member: <MemFIRST><MemMI><MemLAST> Member #: <HIC#> Issue ID: <ISSUID> PCP: <PCPNAM> PCP Tel: <PCPPHN> Beneficiary ID: <MEMID> MEMBER CANNOT BE CHARGED Copays: \$0</p>	<p>MI HEALTH LINK</p> <p>RxBIN: <RXBIN> RxPCN: <RXPCN> RxGRP: <RXGRP> RxID: <HIC#></p> <p>MedicareRx Prescription Drug Coverage</p> <p>MyMolina.com</p>
<p>H7844-001</p>	
<p>In an emergency, call 911 or go to the nearest emergency room. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice Line.</p> <p>Contact Member Services for pharmacy, dental and vision benefit assistance. Member Services: <MS No> or TTY: 711</p> <p>24-Hour Nurse Advice Line: (844)-489-2541 or TTY: 711</p> <p>Behavioral Health Services: Wayne (313) 344-9099 TTY (800) 630-1044, Macomb (855) 996-2264 TTY 711</p> <p>24 Hr Behavioral Health Crisis Line: Wayne (800) 241-4949, Macomb (586) 307-9100</p> <p>Claim Inquiry: (855) 322-4077</p> <p>Submit Claims To:</p> <p>Medical/Hospital: PO Box 22668, Long Beach, CA 90801, please call Member Services (see above). EDI Claims: Emdeon Payer ID: 38334</p> <p>MolinaHealthcare.com/Duals</p>	

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Michigan Medicaid card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Molina Dual Options Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. See Chapter 7 to see what to do if you get a bill from a provider.

J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Molina Dual Options network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 7).

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



You can ask for a *Provider and Pharmacy Directory* by calling Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. You can also see the *Provider and Pharmacy Directory* at www.MolinaHealthcare.com/Duals or download it from this website.

Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

Definition of network providers

- Molina Dual Options' network providers include:
 - Doctors, nurses, and other health care professionals that you can go to as a member of our plan;
 - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; and
 - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Michigan Medicaid.

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

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed 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 pay for them.

Call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST for more information. Both Member Services and Molina Dual Options' 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 which prescription drugs are covered by Molina Dual Options.

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. See Chapter 5 for more information on these rules and restrictions.

Each year, we will 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, visit www.MolinaHealthcare.com/Duals or call (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST.

J4. The Explanation of Benefits

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

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



The *Explanation of Benefits* tells you the total amount you or others on your behalf have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Member Services.

K. How to keep your membership record up to date

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

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- Any liability claims, such as claims from an automobile accident
- Admission to a nursing home or hospital
- Care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become part of a clinical research study

If any information changes, please let us know by calling Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

You are able to update your member information online and through the HealthinHand app. Please visit www.MyMolina.com to change your PCP, request an ID card or update your mailing address and phone number.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, see Chapter 8.



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 Molina Dual Options and your health care benefits. You can also use this chapter to get information about how to contact your Care Coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. How to contact Molina Dual Options Member Services

METHOD	CONTACT INFORMATION
CALL	<p>(855) 735-5604 This call is free.</p> <p>Monday - Friday, 8 a.m. to 8 p.m., EST</p> <p>Assistive technologies, including self-service and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>Monday - Friday, 8 a.m. to 8 p.m., EST</p>
FAX	<p>For Medical Services:</p> <p>Fax: (248) 925-1767</p> <p>For Part D (Rx) Services:</p> <p>Fax: (866) 290-1309</p>
WRITE	<p>For Member Services/Medicaid Drugs:</p> <p>880 West Long Lake Road, Suite 600 Troy, MI 48098</p> <p>For Part D (Rx) Services:</p> <p>7050 Union Park Center, Suite 200 Midvale, UT 84047</p>
WEBSITE	www.MolinaHealthcare.com/Duals

A1. When to contact Member Services

- Questions about the plan
- Questions about claims, billing, or Member ID Cards
- 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 will pay for your health services.
 - Call us if you have questions about a coverage decision about health care.
 - To learn more about coverage decisions, see Chapter 9.
- Appeals about your health care

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- 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.
- To learn more about making an appeal, see Chapter 9.
- 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 the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F below).
 - If your complaint is about a coverage decision about your health care, you can make an appeal (see the section above).
 - You can send a complaint about Molina Dual Options right to Medicare. You can use an online form at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
 - To learn more about making a complaint about your health care, see Chapter 9.
- Coverage decisions about your drugs
 - A coverage decision about your drugs is a decision about:
 - your benefits and covered drugs, **or**
 - the amount we will pay for your drugs.
 - This applies to your Part D drugs, Michigan Medicaid prescription drugs, and Michigan Medicaid over-the-counter drugs.
 - For more on coverage decisions about your prescription drugs, see Chapter 9.
- Appeals about your drugs
 - An appeal is a way to ask us to change a coverage decision.
 - To appeal a coverage decision about a drug, call Member Services or submit your appeal in writing:



Contact Information			
If your appeal is about a: Part D drug	Here's what to do: You must file an appeal within 60 days of the coverage decision.	You'll receive a decision within: 7 calendar days	For Appeals on Part D drugs, mail to: Medicare Pharmacy 7050 Union Park Center, Suite 200 Midvale, UT 84047 Fax to: (866) 290-1309
If your appeal is about a: Non-Part D drug (these have an asterisk next to them in the Drug List)	Here's what to do: You must file an appeal within 60 days of the coverage decision.	You'll receive a decision within: 30 calendar days (plus 14 day extension)	For Appeals on Medicaid drugs, mail to: 880 W Long Lake Rd, Suite 600 Troy, MI 48098 In Person Delivery Address: 880 W Long Lake Rd, Suite 600 Troy, MI 48098 Fax to: (248) 925-1766

- For more on making an appeal about your prescription drugs, see Chapter 9.
- Complaints about your drugs
 - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
 - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (See the section above)
 - You can send a complaint about Molina Dual Options right to Medicare. You can use an online form at <https://www.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 prescription drugs, see Chapter 9.
- Payment for health care or drugs you already paid for
 - For more on how to ask us to pay you back, or to pay a bill you got, see Chapter 7.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9 for more on appeals.

B. How to contact your Care Coordinator

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

CALL	(855) 735-5604 This call is free. Monday - Friday, 8 a.m. to 8 p.m., EST 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., EST
WRITE	Molina Dual Options 880 West Long Lake Road, Suite 600 Troy, MI 48098
WEBSITE	www.MolinaHealthcare.com/Duals

B1. When to contact your Care Coordinator

- Questions about your health care
- Questions about getting behavioral health services, transportation, and long term supports and services (LTSS)
- Questions about any other supports and services you need

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Personal Care Services
- Home health care

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



See Chapter 4 for additional information about Home and Community Based waiver services.

C. How to contact the 24 Hour Nurse Advice 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 and has been since 2007. 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 since 2010, 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.

CALL	(844) 489-2541 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

C1. When to contact the 24 Hour Nurse Advice Line

- Questions about your health care

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



D. How to contact the PIHP General Information Line and Behavioral Health Crisis Line

Behavioral health services will be available to Molina Dual Options members through the local Prepaid Inpatient Health Plan (PIHP) provider network. Members getting services through the PIHP will continue to get them according to their plan of care. Molina Dual Options will provide the personal care services previously provided by the Department of Health and Human Services (DHHS) Home Help program. Other medically necessary behavioral health, intellectual/developmental disability, and substance use disorder services, including psychotherapy or counseling (individual, family, and group) when indicated, are available and coordinated through the health plan and PIHP.

PIHP General Information Line:

Method	CONTACT INFORMATION
CALL	<p>For Wayne County residents, please contact Detroit Wayne Integrated Health Network at 1-313-344-9099.</p> <p>Monday through Friday, 8 a.m. - 4:30 p.m., EST</p> <p>In the event of a mental health emergency in Wayne County, please call the 24 hour behavioral health crisis line at 1-800-241-4949.</p> <p>For Macomb County residents, please contact Macomb County Community Mental Health at 1-855-996-2264.</p> <p>Monday through Friday, 8 a.m. - 8 p.m., EST</p> <p>This call is free.</p> <p>In the event of a mental health emergency in Macomb County, please call the 24 hour behavioral health crisis line at 1-586-307-9100</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>Please contact the listed TTY telephone numbers for: Detroit Wayne Integrated Health Network: 1-800-630-1044, or Macomb County Community Mental Health: 711</p> <p>This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Monday - Friday, 8 a.m. to 5 p.m., EST</p>

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



D1. When to contact the PIHP General Information Line

- Questions about behavioral health services
- Where and how to get an assessment
- Where to go to get services
- A list of other community resources

Behavioral Health Crisis Line:

METHOD	CONTACT INFORMATION
CALL	<p>In the event of a mental health emergency in Wayne County, please call the 24 hour behavioral health crisis line at 1-800-241-4949.</p> <p>In the event of a mental health emergency in Macomb County, please call the 24 hour behavioral health crisis line at 1-586-307-9100.</p> <p>This call is free.</p> <p>24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>24 hours a day, 7 days a week</p>

D2. When to contact the Behavioral Health Crisis Line

- Suicidal thoughts
- Information on mental health/illness
- Substance abuse/addiction
- To help a friend or loved one
- Relationship problems
- Abuse/violence
- Economic problems causing anxiety/depression
- Loneliness
- Family problems
- If you are experiencing a life or death emergency, please call 9-1-1 or go to the nearest hospital.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP).

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

CALL	1-800-803-7174 This call is free. Hours of operation are: Monday through Friday, 8 AM to 5 PM.
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	6105 St Joe Hwy #204 Lansing Charter Township, MI 48917
EMAIL	info@mmapinc.org
WEBSITE	http://mmapinc.org/

E1. When to contact MMAP

- Questions about your Medicare and Michigan Medicaid health insurance
 - MMAP counselors can answer your questions about changing to a new plan and help you:
 - understand your rights,
 - understand drug coverage, such as prescription and over-the-counter drugs,
 - understand your plan choices,
 - make complaints about your health care or treatment, **and**
 - straighten out problems with your bills.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



F. How to contact the Quality Improvement Organization (QIO)

Our state uses an organization called Livanta for quality improvement. 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	1-888-524-9900 This call is free.
TTY	1-888-985-8775 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta 10820 Guilford Rd, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

F1. When to contact Livanta

- Questions about your health care
 - 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. How to contact 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	<p>1-800-MEDICARE (1-800-633-4227)</p> <p>Calls to this number are free, 24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p>
WEBSITE	<p>http://www.medicare.gov</p> <p>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting “Forms, Help & Resources” and then clicking on “Phone numbers & websites.”</p> <p>The Medicare website has the following tool to help you find plans in your area:</p> <p>Medicare Plan Finder: Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Find health & drug plans.”</p> <p>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, print it out, and send it to you.</p>

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



H. How to contact Michigan Medicaid

Michigan Medicaid helps with medical and long term supports and services costs for people with limited incomes and resources.

You are enrolled in Medicare and in Michigan Medicaid. If you have questions about the help you get from Michigan Medicaid, call the Beneficiary Help Line.

CALL	Beneficiary Help Line 1-800-642-3195 This call is free. Office hours are Monday through Friday, 8 AM to 7 PM.
TTY	1-866-501-5656 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	PO Box 30479 Lansing, MI 48909-7979

Michigan Medicaid eligibility is determined by the Michigan Department of Health and Human Services. If you have questions about your Michigan Medicaid eligibility or yearly renewal, contact your Department of Health and Human Services Specialist. For general questions about Department of Health and Human Services assistance programs, call 1-855-275-6424 Monday through Friday, 8 AM to 5 PM.

I. How to contact the MI Health Link Ombudsman program

The MI Health Link Ombudsman program helps people enrolled in MI Health Link. They work 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 MI Health Link Ombudsman also helps people enrolled in Michigan Medicaid with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-888-746-6456
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
EMAIL	help@mhlo.org
WEBSITE	www.mhlo.org

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



J. How to contact the Michigan Long Term Care Ombudsman program

The Michigan Long Term Care Ombudsman Program helps people learn about nursing homes and other long term care settings. It also helps solve problems between these settings and residents or their families.

METHOD	CONTACT INFORMATION
CALL	1-866-485-9393
WRITE	State Long Term Care Ombudsman 15851 South US 27, Suite 73 Lansing, MI 48906
EMAIL	https://mltcop.org/contact
WEBSITE	https://mltcop.org/

K. Other resources

Various Long Term Services and Support services are available to members in the Home and Community-Based Services waiver under the MI Health Link program. Please contact your Care Coordinator for information about accessing these services and the providers available in your community as this list is subject to change.

State Enrollment Broker: Michigan ENROLLS: (800) 975-7630

Michigan Medicaid Beneficiary Help Line: (800) 642-3195

Macomb County Resources:

Macomb County Office of Senior Services
21885 Dunham, Suite 6
Clinton Township, MI 48036
(586) 469-5228
<https://mca.macombgov.org/MCA-Seniors-Information>

VerKuilen Building
21885 Dunham Road, Suite 10, Clinton Township, MI 48036
mca@macombgov.org
(586) 469-6999

Area Agency on Aging 1-B
29100 Northwestern Highway, Suite 400
Southfield, MI 48034
(248) 357-2255 or (800) 852-7795

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Macomb County Access Location
39090 Garfield, Suite 102
Clinton Twp., MI 48038
(586) 226-0309
(800) 852-7795
Fax: (248) 262-9971

Wayne County Resources:

AAA:
Detroit Agency on Aging
133 Brewery Park Blvd., Suite 200
Detroit, MI 48207
(313) 446-4444

The Senior Alliance, Inc.
3850 Second St., Suite 201
Wayne, MI 48184
(734) 722-2830



Chapter 3: Using the 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 Molina Dual Options. It also tells you about your Care Coordinator, 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 when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). *Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.*

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A. Information about “services,” “covered services,” “providers,” and “network providers”

Services are health care, long term supports and services, supplies, behavioral health, 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 and long term supports and services are listed in the Benefits Chart in Chapter 4.

Providers are doctors, nurses, and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long term supports and services.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you will pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long-term supports and services (LTSS) covered by the plan

Molina Dual Options covers all services covered by Medicare and Michigan Medicaid. This includes behavioral health services, long term support and services, and prescription drugs.

Molina Dual Options will generally pay for the health care and other supports and services you get if you follow the plan rules. The only exceptions are that you pay any Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services or any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

To be covered by our plan:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4 of this handbook).
- The care must be **medically necessary**. Medically necessary means you need services 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.
- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to see another doctor. As a plan member, you must choose a network provider to be your PCP.
 - In most cases, your network PCP must give you approval before you can see someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Molina Dual Options may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. To learn more about referrals, see page 29.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 29.
- To learn more about choosing a PCP, see page 29.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
 - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what emergency or urgently needed care means, see Section I, page 32.
 - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. If you are seeking care from an out of network provider, an authorization is required. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to see an out-of-network provider, see Section D, page 29.
 - The plan covers kidney dialysis 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.
 - When you first join the plan, you can keep getting services and seeing the doctors and other providers you go to now for at least 90 days from your enrollment start date. If you get services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the Prepaid Inpatient Health Plan (PIHP), you will be able to get services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time period. Call Molina Dual Options for information about nursing home services.

C. Information about your Care Coordinator

C1. What a Care Coordinator is

A Care Coordinator is a person who will work with you to help you get the Medicare and Michigan Medicaid covered supports and services you need and want.

C2. How you can contact your Care Coordinator

If you want to contact your Care Coordinator, please call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. The call is free.

C3. How you can change your Care Coordinator

You or your caregiver may request to a change your Care Coordinator by calling your Care Coordinator or Member Services. On occasion, Molina may make changes to member Care Coordinator assignments based on member needs (cultural/linguistic/physical/ behavioral health) or location.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



D. Care from primary care providers, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of “PCP,” and what does the PCP do for you

- A primary care physician (PCP) is the doctor you will see for most of your preventive health care needs. Your PCP will also help you seek care from specialist and providers of services.
- A PCP is a physician, advanced practice nurse practitioner, physician assistant and/or medical home/clinic (Federally Qualified Health Centers (FQHC)) who gives you routine health care. You may also be able to have a specialist act as your PCP, when the specialist is willing to provide your routine healthcare. Please contact Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.
- When you have needs outside of the PCP's area of specialty, you will be referred to a specialist for services that are needed to keep you healthy. Your PCP will ensure all of your care is coordinated with a specialist and that your Care Coordinator is informed about services you may need.
- You can find our current list of providers on the web at MolinaHealthcare.com/Duals or call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

Your choice of PCP

You may have chosen your PCP at the time of enrollment with Molina Dual Options. The PCP you selected should be on your Molina Dual Options ID card. If you did not have a chance to choose a PCP or if the PCP you selected is not on your ID card, you may contact our Member Services department for help. Call (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP if the one that you have now leaves our network.

You can call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST if you want more information about our Molina Dual Options providers or if you need help changing your PCP. Member Services will make the PCP change effective as of the current month. For some providers, you may need a referral from your PCP (except for emergency and out of area urgent care services).

Services you can get without first getting approval from your PCP

In most cases, you will need approval from your PCP before seeing other providers. This approval is called a referral. You can get services like the ones listed below without first getting approval from your PCP:

- 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, when you are outside the plan's service area).

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots 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.
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.

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. Here are a few examples:

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

Your PCP can help you find a specialist if you need services for a specific condition or specialty service.

If you need services from an out of network provider, your PCP will get authorization from the health plan. Your PCP will send any documentation needed by the health plan to make the decision on your authorization. If your PCP's authorization request is denied, Molina Dual Options will consider coverage based on medical necessity. If you would like to know what benefits require prior authorization, see the benefits charts in Chapter 4.

D3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will 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 will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please contact Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



D4. How to get care from out-of-network providers

Most services will be provided by our network providers. If you need services that cannot be provided within our network, Molina Dual Options will pay for the cost of an out of network provider, as long as the service is approved by your PCP and the plan. If you go to providers who are not in the Molina Dual Options network without prior authorization, you may have to pay the bill.

If you need services from an out of network provider, you or the out of network provider may contact your Care Coordinator at (855) 735-5604, TTY: 711, Monday - Friday, 8:30 a.m. to 5 p.m., EST prior to receiving the services. Your Care Coordinator will assist you and/or the provider in getting the necessary information to obtain the prior authorization.

If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Michigan Medicaid.
- 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.

E. How to get long term supports and services (LTSS)

Your Care Coordinator can help determine if you need long term supports and services and how you get them. To speak with your Care Coordinator, you may call Member Services. Please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

F. How to get behavioral health services

Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about coverage decisions and appeals on behavioral health services. If you reside in Wayne County, including Detroit residents, you will contact the Detroit Wayne Integrated Health Network. Call 1-313-344-9099 (TTY: 1-800-630-1044). If you reside in the Macomb County, you will contact Macomb County Community Mental Health. Call 1-855-996-2264 (TTY: 711).

G. How to participate in self-determination arrangements

Self-Determination promotes personal choice and control over the delivery of (Long Term Services and Supports (LTSS), including who provides services, how they are delivered, and hiring and firing personal attendants and/or home care workers.



G1. What arrangements that support self-determination are

Self-determination is an option available to enrollees getting services through the MI Health Link HCBS home and community-based waiver program. It is a process that allows you to design and exercise control over your own life.

- This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an “individual budget.”
- If you choose to do so, you would also have control over the hiring and management of providers.

G2. Who can get arrangements that support self-determination

Arrangements that support self-determination are available for enrollees who get services through the home and community-based services waiver program called MI Health Link HCBS.

G3. How to get help in employing providers

You may work with your Care Coordinator to get help employing providers.

H. How to get transportation services

Transportation is provided to you if you have no way to get to your PCP or other medical appointments.

In order to receive transportation services, please contact our Member Services department. Call Molina Dual Options at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

Transportation must be coordinated at least three (3) business days prior to appointment for assistance.

Requests for urgent transportation appointments can be scheduled without three (3) day notice.

For trips that require mileage reimbursement, Enrollees must contact Molina Healthcare, at least 72 hours in advance for non-urgent trips or same day for urgent/hospital discharges. Molina Healthcare will mail a mileage reimbursement instruction sheet and log to the enrollee's residence. Enrollees will be responsible for completing the log. The log must be signed by the enrollee's physician. The enrollee will be responsible for returning the completed log to Molina Healthcare at the address provided on the instruction sheet to obtain reimbursement for all miles to medical appointments and for covered services and benefits.

I. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

I1. Care when you have a medical emergency

Definition of 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**

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- 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.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to 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 will not have to pay for emergency services because of a delay in telling us. You can contact Molina Dual Options at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

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. You can contact Molina Dual Options at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

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 our plan. 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.

What to do if you have a behavioral health emergency

In the event of a mental health emergency in Wayne County, please call the 24 hour behavioral health crisis line at 1-800-241-4949.

In the event of a mental health emergency in Macomb County, please call the 24 hour behavioral health crisis line at 1-586-307-9100.

This call is free.

24 hours a day, 7 days a week

We have free interpreter services for people who do not speak English.

When to contact the Behavioral Health Crisis Line

- Suicidal thoughts

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- Information on mental health/illness
- Substance abuse/addiction
- To help a friend or loved one
- Relationship problems
- Abuse/violence
- Economic problems causing anxiety/depression
- Loneliness
- Family problems
- If you are experiencing a life or death emergency, please call 9-1-1 or go to the nearest hospital.

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 might go in for emergency care and have the doctor say it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care only if:

- you go to a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

12. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

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

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

Urgent care can be accessed using any available urgent care center. You may also call the 24 hour Nurse Advice Line at (844) 489-2541. TTY users should call 711.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.



Our plan does not cover urgently needed care or any other care that you get outside the United States.

I3. 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 Molina Dual Options.

Please visit our website for information on how to obtain needed care during a declared disaster: www.MolinaHealthcare.com/Duals.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at *no cost to you*. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

J. What to do if you are billed directly for services covered by our plan

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

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

If you have paid for your covered services or if you have gotten a bill for covered medical services, see Chapter 7 to learn what to do.

J1. What to do if services are not covered by our plan

Molina Dual Options covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (see Chapter 4), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will 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 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go 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 limits are and how close you are to reaching them.



K. Coverage of health care services when you are in a clinical research study

K1. 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. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare or our plan approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

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

You do need to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your Care Coordinator should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay 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 are covered for most items and services 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.

We will pay any costs if you volunteer for a clinical research study that Medicare does not approve but that our plan approves. If you are part of a study that Medicare or our plan has **not approved**, you **will** have to pay any costs for being in the study.

K3. Learning 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 (<https://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.



L. How your health care services are covered when you get care in a religious non-medical health care institution

L1. 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 will cover care in a religious non-medical health care institution.

You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

L2. Getting 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, the following applies:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Inpatient stays require authorization from the plan. Our plan will cover your inpatient stay when it is medically necessary. (See the Benefits Chart in Chapter 4).

M. Durable Medical Equipment (DME)

M1. DME as a member of our plan

DME means certain items ordered by a provider 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, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



In this section, we discuss DME you must rent. As a member of Molina Dual Options, you usually will not own DME, no matter how long you rent it.

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

M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2020* Handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) 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.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or a Medicare Advantage plan.



Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Molina Dual Options 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 the *Member Handbook*.

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A. Your covered services

This chapter tells you what services Molina Dual Options pays for. 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.

You pay nothing for your covered services as long as you follow the plan's rules. See Chapter 3 for details about the plan's rules. The only exceptions are that you pay any:

- Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services.
- Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---.00.html.

If you need supports and services related to a behavioral health condition, intellectual or developmental disability, or a substance use disorder, please work with your Care Coordinator to get services provided through the Prepaid Inpatient Health Plan (PIHP). You will also get a PIHP Member Handbook which will further explain the PIHP eligibility and covered specialty services.

Depending on eligibility criteria, some items, supplies, supports and services may be offered through our plan or the PIHP. To ensure our plan and the PIHP are not paying for the same items, supplies, supports or services, your Care Coordinator can help you get what you need from either our plan or the PIHP. Services from the PIHP have different eligibility or medical necessity criteria. See Section F in this chapter and the PIHP handbook for more information.

If you need help understanding what services are covered, call your Care Coordinator and/or Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

B. Rules against providers charging you for services

We do not allow Molina Dual Options 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, see Chapter 7 or call Member Services.

C. Our plan's Benefits Chart

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections:

- General Services
 - Offered to all enrollees
- Home and Community-Based Services (HCBS) Waiver
 - Offered only to enrollees who:

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- require nursing facility level of care but are not residing in a nursing facility, and
- have a need for covered waiver services


We will pay for the services listed in the Benefits Chart only when the following rules are met.

You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below. The only exception are that you pay any Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services or any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting

https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

- Your Medicare and Michigan Medicaid covered services must be provided according to the rules set by Medicare and Michigan Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services 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.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) that is providing your care. In most cases, your PCP must give you approval before you can see someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3 has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization are marked in the Benefits Chart by an asterisk (*).
- All preventive services are free. You will see this apple 🍏 next to preventive services in the Benefits Chart.

D. The Benefits Chart

	General Services that our plan pays for	What you must pay
	Abdominal aortic aneurysm screening The plan will 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



If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit

www.MolinaHealthcare.com/Duals.







	General Services that our plan pays for	What you must pay
	<p>Adaptive Medical Equipment and Supplies*</p> <p>The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include:</p> <ul style="list-style-type: none"> • shower chairs/benches • lift chairs • raised toilet seats • reachers • jar openers • transfer seats • bath lifts/room lifts • swivel discs • bath aids such as long handle scrubbers • telephone aids • automated/telephone or watches that assist with medication reminders • button hooks or zipper pulls • modified eating utensils • modified oral hygiene aids • modified grooming tools • heating pads • sharps containers • exercise items and other therapy items • voice output blood pressure monitor • nutritional supplements such as Ensure <p>Contact your Molina Dual Options Care Coordinator for assistance with services listed in this section.</p>	\$0




	General Services that our plan pays for	What you must pay
	<p>Alcohol misuse screening and counseling</p> <p>The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>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.</p>	\$0
	<p>Ambulance services*</p> <p>Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan.</p> <p>In cases that are not emergencies, the plan 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.</p> <p>Prior authorization required for non-emergent ambulance only.</p>	\$0
	<p>Annual wellness visit</p> <p>If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months.</p> <p>Note: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.</p>	\$0
	<p>Bone mass measurement</p> <p>The plan will 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.</p> <p>The plan will pay for the services once every 24 months or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.</p>	\$0


If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.




	General Services that our plan pays for	What you must pay
	Breast cancer screening (mammograms) The plan will pay for the following services: <ul style="list-style-type: none"> • 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
	Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. The plan also covers <i>intensive</i> cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	\$0
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: <ul style="list-style-type: none"> • discuss aspirin use, • check your blood pressure, or • give you tips to make sure you are eating well. 	\$0
	Cardiovascular (heart) disease testing The plan pays 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
	Cervical and vaginal cancer screening The plan will pay for the following services: <ul style="list-style-type: none"> • 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 	\$0


	General Services that our plan pays for	What you must pay
	<p>Chiropractic services*</p> <p>The plan will pay for the following services:</p> <ul style="list-style-type: none"> • Adjustments of the spine to correct alignment • Diagnostic x-rays • Prior Authorization is required after 18 visits. 	\$0
	<p>Colorectal cancer screening</p> <p>For people 50 and older, the plan will pay for the following services:</p> <ul style="list-style-type: none"> • 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 <p>For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months.</p> <p>For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).</p>	\$0




	General Services that our plan pays for	What you must pay
	<p>Community Transition Services*</p> <p>The plan will pay for one-time expenses for you to transition from a nursing home to another residence where you are responsible for your own living arrangement. You must have resided in the nursing home for ninety (90) consecutive days to get this service. Covered services may include:</p> <ul style="list-style-type: none"> • housing or security deposits • utility hook-ups and deposits (excludes television and internet) • furniture (limited) • appliances (limited) • moving expenses (excludes diversion or recreational devices) • cleaning including pest eradication, allergen control, and over-all cleaning <p>This service does not include ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes. Coverage is limited to once per year.</p>	\$0
	<p>Counseling to stop smoking or tobacco use</p> <p>If you use tobacco but do not have signs or symptoms of tobacco-related disease:</p> <ul style="list-style-type: none"> • The plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"> • The plan will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. <p>The plan offers 8 counseling sessions to stop smoking or tobacco use in addition to your Medicare benefit.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Dental services</p> <p>Molina Dual Options will pay for the following services:</p> <ul style="list-style-type: none"> • Examinations and evaluations are covered once every six months • Cleaning is a covered benefit once every six months • Silver diamine fluoride treatment is covered with a maximum of six applications per lifetime • X-rays <ul style="list-style-type: none"> ◦ Bitewing x-rays are a covered benefit only once in a 12-month period ◦ A panoramic x-ray is a covered benefit once every five years ◦ A full mouth or complete series of x-rays is a covered benefit once every five years ◦ Fillings • Tooth extractions • Complete or partial dentures are covered once every five years 	\$0
	<p>Depression screening</p> <p>The plan will 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, which include referrals to your primary care provider or the Prepaid Inpatient Health Plan (PIHP) for further assessment and services.</p>	\$0

	General Services that our plan pays for	What you must pay
	<p>Diabetes screening</p> <p>The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Diabetic self-management training, services, and supplies</p> <p>The plan will pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> 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, the plan will pay for the following: <ul style="list-style-type: none"> One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) <p>The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.</p> <ul style="list-style-type: none"> The plan will pay for training to help you manage your diabetes, in some cases. 	\$0



	General Services that our plan pays for	What you must pay
	<p>Durable medical equipment (DME) and related supplies*</p> <p>(For a definition of “Durable medical equipment (DME),” see Chapter 12 of this handbook.)</p> <p>The following items are covered:</p> <ul style="list-style-type: none"> • 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 • Walkers <p>The following items are also covered:</p> <ul style="list-style-type: none"> • Breast Pumps • Canes • Commodes • CPAP Device • Enteral Nutrition • Home Uterine Activity Monitor • Incontinence Supplies • Insulin Pump and Supplies • Lifts, Slings and Seats • Lymphedema Pump • Negative Pressure Wound Therapy <p>This benefit is continued on the next page</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Durable medical equipment (DME) and related supplies* (continued)</p> <ul style="list-style-type: none"> • Orthopedic Footwear • Orthotics • Osteogenesis Stimulator • Ostomy Supplies • Parenteral Nutrition • Peak Flow Meter • Pressure Gradient Products • Pressure Reducing Support Surfaces • Prosthetics • Pulse Oximeter • Surgical Dressings • Tracheostomy Care Supplies • Transcutaneous Electrical Nerve Stimulator • Ventilators • Wearable Cardioverter-Defibrillators <p>Other items may be covered.</p> <p>Some DME is provided based on Michigan Medicaid policy. Requirements for referral, physician order and assessment apply along with limitations on replacement and repair.</p> <p>Other items may be covered, including environmental aids or assistive/adaptive technology. Molina Dual Options may also cover you learning how to use, modify, or repair your item. Your Integrated Care Team will work with you to decide if these other items and services are right for you and will be in your Plan of Care.</p> <p>Some items may also be covered through the Prepaid Inpatient Health Plan (PIHP) based on eligibility criteria. These items should be paid for by either our plan or the PIHP, not by both.</p> <p>We will pay for all medically necessary DME that Medicare and Michigan Medicaid 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.</p>	




	General Services that our plan pays for	What you must pay
	<p>Emergency care</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • given by a provider trained to give emergency services, and • needed to treat a medical emergency. <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ◦ 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 that of your unborn child. <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you may have to 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 the plan approves your stay.</p> <p>You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, without prior authorization.</p> <p>Emergency medical care is not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Family planning services</p> <p>The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>The plan will pay for the following services:</p> <ul style="list-style-type: none"> • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling <p>The plan will also pay for some other family planning services. However, you must see a provider in the plan's network for the following services:</p> <ul style="list-style-type: none"> • Treatment for AIDS and other HIV-related conditions • Genetic testing* 	\$0



	General Services that our plan pays for	What you must pay
	<p>Fitness Benefit</p> <p>Molina Dual Options partners with American Specialty Health Fitness, Inc. (ASH Fitness) to provide the FitnessCoach® program, a membership to participating fitness centers or membership to the FitnessCoach® Home Fitness Program for members who are unable to visit a fitness center, or prefer to work out from home.</p> <p>Simply choose a participating fitness center online at FitnessCoach.com or call FitnessCoach® customer service at 1-888-369-2746 or TTY 711, Monday - Friday, 8:00 a.m. - 9:00 p.m. (Eastern Time) excluding holidays. Once you have chosen a fitness center, take the fitness card located in your Welcome Kit to the fitness center of your choice and begin using the centers services the same day.</p> <p>If you wish to enroll in the FitnessCoach® Home Fitness program, you can enroll online at FitnessCoach.com or by calling FitnessCoach® customer service at 1-888-369-2746 or TTY 711, Monday - Friday, 8:00 a.m. - 9:00 p.m. (Eastern Time) excluding holidays.</p>	\$0
	<p>Health and wellness education programs</p> <p>There are several plan programs that aim to help you improve your health and keep you well. The plan offers special programs for specific illnesses like asthma, diabetes or to quit smoking. We also supply information about important health topics like immunizations, cancer screening and medication safety.</p> <p>The plan offers the following health and wellness education programs:</p> <ul style="list-style-type: none"> • Health Education • Nutritional/Dietary Benefit <ul style="list-style-type: none"> ◦ Up to 12 nutritional counseling sessions over the phone, between 30 - 60 minutes each Your doctor may provide a referral for this benefit. • 24-Hour Nurse Advice Line <p>Available 24 hours a day, 7 days a week.</p>	\$0




	General Services that our plan pays for	What you must pay
	<p>Hearing services*</p> <p>The plan pays 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.</p> <p>For adults aged 21 and older, the plan pays for evaluation and fitting for a hearing aid twice per year and pays for a hearing aid once every five years. Referral and authorization are required.</p>	\$0
	<p>Home health agency care*</p> <p>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.</p> <p>The plan will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 • Home health aide when provided with a nursing service 	\$0
	<p>HIV screening</p> <p>The plan pays for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> • Ask for an HIV screening test, or • Are at increased risk for HIV infection. • For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy. 	\$0



	General Services that our plan pays for	What you must pay
	<p>Hospice care</p> <p>You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>The plan will pay for the following while you are getting hospice services:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare.</p> <ul style="list-style-type: none"> • See Section E of this chapter for more information. <p>For services covered by Molina Dual Options but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • Molina Dual Options will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. <p>For drugs that may be covered by Molina Dual Options' Medicare Part D benefit:</p> <ul style="list-style-type: none"> • Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5. <p>Note: If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You can contact your Care Coordinator at (855) 735-5604, TTY: 711, Monday - Friday, 8:30 a.m. to 5 p.m., EST.</p>	<p>\$0</p>



	General Services that our plan pays for	What you must pay
	Immunizations The plan will pay for the following services: <ul style="list-style-type: none"> • 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 • Other vaccines if you are at risk and they meet Medicare Part B or <i>Michigan</i> Medicaid coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more.	\$0




	General Services that our plan pays for	What you must pay
	<p>Inpatient stay: Covered services in a hospital or skill nursing facility (SNF)*</p> <p>The plan will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 use disorder services • Blood, including storage and administration <ul style="list-style-type: none"> ◦ The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. ◦ The plan will pay for all other parts of blood beginning with the first pint used. • Physician services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. <p>This benefit is continued on the next page</p>	<p>\$0</p> <p>You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.</p> <p>Our plan covers an unlimited number of days if medically necessary.</p>





	General Services that our plan pays for	What you must pay
	<p>Inpatient stay: Covered services in a hospital or skill nursing facility (SNF)* (continued)</p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant.</p> <p>If transplant providers accept Molina Dual Options, you can get transplant services locally. You may also get transplant services outside of the service area. You will receive your transplant with a network provider, if Molina Dual Options cannot provide a transplant within the network we will authorize the service at a distant location outside the service area and will arrange or pay for lodging and travel costs for you and one other person.</p> <p>If you require travel for your approved transplant, please discuss with your Molina Dual Options Care Coordinator</p>	
	<p>Inpatient behavioral health care*</p> <p>The plan will refer you to the Prepaid Inpatient Health Plan (PIHP) for this service. Refer to Section E in this chapter for more information.</p> <p>The Prepaid Inpatient Health Plan must approve admission for a psychiatric inpatient hospital stay.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Kidney disease services and supplies</p> <p>The plan will pay for the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will 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 • Inpatient dialysis treatments if you are 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 <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.</p>	\$0
	<p>Lung cancer screening</p> <p>The plan will pay for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • Are aged 55-77, 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 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. <p>After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.</p>	\$0




	General Services that our plan pays for	What you must pay
	<p>Meal Benefit</p> <p>This program is uniquely designed to keep you healthy and strong while you are recovering after an inpatient hospital stay or Skilled Nursing Facility (SNF) stay. If you qualify, your plan Care Coordinator will enroll you in the program.</p> <p>You may also qualify if your doctor requests this benefit for you because of your chronic condition.</p> <p>This benefit provides 2 meals a day for 14 days. With additional approval, you may get another 14 days of 2 meals a day. The maximum is 56 meals over 4 weeks.</p>	\$0
	<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor.</p> <p>The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) 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 referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.</p>	\$0
	<p>Medicare Diabetes Prevention Program (MDPP)</p> <p>The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> • long-term dietary change, and • increased physical activity, and • ways to maintain weight loss and a healthy lifestyle. 	\$0

	General Services that our plan pays for	What you must pay
	<p>Medicare Part B prescription drugs*</p> <p>These drugs are covered under Part B of Medicare. Molina Dual Options will pay for the following drugs:</p> <ul style="list-style-type: none"> • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • 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. These drugs are paid for 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 <p>Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.</p>	\$0
	<p>Non-emergency medical transportation*</p> <p>The plan will cover unlimited transportation for you to travel to or from your medical appointments and the pharmacy if it is a covered service. Types of non-emergency transportation include:</p> <ul style="list-style-type: none"> • Wheelchair equipped van • Service car • Taxicab 	\$0



	General Services that our plan pays for	What you must pay
	<p>Nursing facility care*</p> <p>The plan will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • A semi-private room, or a private room if it is medically needed • 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 • 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 <p>You will 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:</p> <ul style="list-style-type: none"> • 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 significant other lives at the time you leave the hospital • The nursing home where you were living when you enrolled in Molina Dual Options <p>This service is intended to be long term custodial care and does not overlap with skilled nursing facility care.</p> <p>You must meet Michigan Medicaid Nursing Facility Level of Care standards to get this service.</p>	<p>\$0</p> <p>When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month.</p> <p>Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.</p>



	General Services that our plan pays for	What you must pay
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will 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
	Opioid treatment services The plan will pay for the following services to treat opioid use disorder: <ul style="list-style-type: none"> • 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
	Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: <ul style="list-style-type: none"> • X-rays • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, beginning with the first pint of blood that you need, including storage and administration. • Radiation (radium and isotope) therapy, including technician materials and supplies* • Surgical supplies, such as dressings* • Other outpatient diagnostic tests* You should talk to your provider and get a referral for blood services.	\$0



	General Services that our plan pays for	What you must pay
	<p>Outpatient hospital services*</p> <p>The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>The plan will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> ◦ Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” ◦ Sometimes you can be in the hospital overnight and still be an “outpatient.” ◦ You can get more information about being an inpatient or an outpatient in this fact sheet: https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf • 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>Outpatient mental health care*</p> <p>Behavioral health benefits for MI Health Link members are managed by Prepaid Inpatient Health Plans (PIHP). For benefit information Macomb County residents should call the Access Center at (855) 996-2264 and Wayne County residents should call the Access Center at (800) 241-4949.</p>	\$0



	General Services that our plan pays for	What you must pay
	Outpatient rehabilitation services* The plan will 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
	Outpatient substance use disorder services* The plan will refer you to the Prepaid Inpatient Health Plan (PIHP) for these services. Refer to Section E in this chapter for more information.	\$0
	Outpatient surgery* The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	\$0
	Over-the-counter (OTC) items We cover non-prescription OTC products like vitamins, sunscreen, pain relievers, cough/cold medicine, and bandages. You get \$75.00 every 3 months that you can spend on plan-approved items. Your quarterly allowance becomes available to use in January, April, July and October. Any dollar amount that you don't use will carry over into the next 3 months. Be sure to spend all of it before the end of the year because it expires at the end of the calendar year. Shipping will not cost you anything. You do not need a prescription from your doctor to get OTC items. You can order by calling 866-420-4010, online at www.MolinaHealthcareOTC.com or through the mail. Refer to your OTC Product Catalog for more information and a complete list of OTC items.	\$0
	Partial hospitalization services* The plan will refer you to the Prepaid Inpatient Health Plan (PIHP) for these services. Refer to Section E in this chapter for more information.	\$0

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.




	General Services that our plan pays for	What you must pay
	Personal Care Services* The plan will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs), which are tasks like bathing, eating, dressing, and toileting. This service can include instrumental activities of daily living (IADLs) but only when there is also a need for an ADL. IADLs include things like shopping, laundry, meal preparation, medication reminders, and taking you to your appointments.	\$0
	Personal Emergency Response System* The plan covers an electronic in home device that secures help in an emergency. You may also wear a portable “help” button to allow for mobility. The system is connected to your phone and programmed to signal a response center once a “help” button is activated.	\$0



	General Services that our plan pays for	What you must pay
	<p>Physician/provider services, including doctor's office visits</p> <p>The plan will pay for the following services:</p> <ul style="list-style-type: none"> • Medically necessary health care or surgery services given in places such as: <ul style="list-style-type: none"> ◦ 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, if your doctor orders it to see whether you need treatment • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis center, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Virtual check-ins (for example, by phone or video chat) with your provider for 5-10 minutes if: <ul style="list-style-type: none"> ◦ 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 sent to your doctor and explanation and follow up by your doctor within 24 hours if: <ul style="list-style-type: none"> ◦ 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 <p>This benefit is continued on the next page</p>	<p>\$0</p>




	General Services that our plan pays for	What you must pay
	Physician/provider services, including doctor's office visits (continued) <ul style="list-style-type: none"> • 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 medical procedure • Non-routine dental care* Covered services are limited to: <ul style="list-style-type: none"> ◦ surgery of the jaw or related structures, ◦ setting fractures of the jaw or facial bones, ◦ pulling teeth before radiation treatments of neoplastic cancer, or ◦ services that would be covered when provided by a physician. 	
	Podiatry services The plan will pay for the following services: <ul style="list-style-type: none"> • 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 • Up to 6 visits per year for routine foot care. 	\$0
	Prostate cancer screening exams For men age 50 and older, the plan will pay for the following services once every 12 months: <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test 	\$0



	General Services that our plan pays for	What you must pay
	<p>Prosthetic devices and related supplies*</p> <p>Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) <p>The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.</p> <p>The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section for details.</p>	\$0
	<p>Pulmonary rehabilitation services</p> <p>The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.</p>	\$0
	<p>Respite*</p> <p>You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.</p> <p>Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.</p> <p>Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.</p> <p>Respite is limited to 14 overnight stays per 365 days unless Molina Dual Options approves additional time.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan will 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.</p> <p>The plan will 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. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Skilled nursing facility (SNF) care*</p> <p>The plan will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ◦ The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. ◦ The plan will pay for all other parts of blood beginning with the first pint used. • 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 <p>A hospital stay is not required to get SNF care.</p> <p>You will 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:</p> <ul style="list-style-type: none"> • 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 lives at the time you leave the hospital 	<p>\$0</p>




	General Services that our plan pays for	What you must pay
	<p>Stipend for maintenance costs of a service animal*</p> <p>The plan will pay up to \$20 per month for maintenance costs of a service animal if:</p> <ul style="list-style-type: none"> • You are receiving personal care services, and • You are certified as disabled due to a specific condition defined by the Americans with Disabilities Act, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, and • The service animal is trained to meet your specific needs of relative to your disability. <p>Your service plan must document that the service animal will be used primarily to meet your personal care needs.</p>	\$0
	<p>Supervised Exercise Therapy (SET)*</p> <p>The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for:</p> <ul style="list-style-type: none"> • 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 <p>The SET program must be:</p> <ul style="list-style-type: none"> • 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




	General Services that our plan pays for	What you must pay
	<p>Urgently needed care</p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> • a non-emergency, or • a sudden medical illness, or • an injury, or • a condition that needs care right away. <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.</p> <p>You may get urgent care services whenever you need it, anywhere in the United States or its territories, without prior authorization.</p> <p>Urgent care is not covered outside the U.S. and its territories except under limited circumstances. Contact plan for details.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>Vision care</p> <p>Routine eye examinations are covered once every two years.</p> <p>The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every two years.</p> <p>The plan will pay for contact lenses for people with certain conditions. Prior authorization is required for contact lenses only.</p> <p>The plan will pay for basic and essential low vision aids (such as magnifiers, readers, and certain other low vision aids.)</p> <p>The plan will 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.</p> <p>For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • people with a family history of glaucoma, • people with diabetes, • African-Americans who are age 50 and older, and • Hispanic Americans who are 65 or older. <p>The plan will 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.)</p> <p>The plan will also pay for corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant.</p>	\$0



	General Services that our plan pays for	What you must pay
	<p>“Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	\$0



Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
<p>Adult Day Program*</p> <p>The plan covers structured day activities at a program of direct care and supervision if you qualify. This service:</p> <ul style="list-style-type: none"> • provides personal attention, and • promotes social, physical and emotional well-being <p>Services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the plan of care.</p>	\$0
<p>Assistive Technology*</p> <p>The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include:</p> <ul style="list-style-type: none"> • van lifts • hand controls • computerized voice system • communication boards • voice activated door locks • power door mechanisms • specialized alarm or intercom • assistive dialing device 	\$0
<p>Chore Services*</p> <p>The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include:</p> <ul style="list-style-type: none"> • heavy household chores (washing floors, windows, and walls) • tacking loose rugs and tiles • moving heavy items of furniture • mowing, raking, and cleaning hazardous debris such as fallen branches and trees <p>The plan may cover materials and disposable supplies used to complete chore tasks.</p>	\$0

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. For more information, visit www.MolinaHealthcare.com/Duals.



Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
<p>Environmental Modifications*</p> <p>The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:</p> <ul style="list-style-type: none"> • installing ramps and grab bars • widening of doorways • modifying bathroom facilities • installing specialized electric systems that are necessary to accommodate medical equipment and supplies 	\$0
<p>Expanded Community Living Supports*</p> <p>To get this service, you must have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc.</p> <p>If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself.</p>	\$0
<p>Fiscal Intermediary Services*</p> <p>The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community-based services authorized in your plan of care. You have the authority to hire the caregiver of your choice.</p>	\$0
<p>Home delivered meals*</p> <p>The plan covers up to two prepared meals per day brought to your home if you qualify.</p>	\$0



Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
<p>Non-medical Transportation*</p> <p>The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify.</p>	\$0
<p>Preventive Nursing Services</p> <p>The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may get other nursing services during the nurse visit to your home. These services are not provided on a continuous basis.</p> <p>Limited to no more than two hours per visit.</p> <p>Members receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services.</p>	\$0
<p>Private Duty Nursing (PDN)*</p> <p>The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability.</p> <p>PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care.</p> <p>You must meet certain medical criteria to qualify for this service.</p> <p>You should talk to your provider and get a referral.</p>	\$0
<p>Respite Care Services*</p> <p>You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.</p> <p>Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.</p> <p>Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.</p>	\$0



E. Benefits covered outside of Molina Dual Options

The following services are not covered by Molina Dual Options but are available through Medicare or Michigan Medicaid.

E1. Hospice care

You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider.

See the Benefits Chart in Section D of this chapter for more information about what Molina Dual Options pays 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 will bill Medicare for your services. Medicare will pay 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 Molina Dual Options' Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5. You pay nothing for these drugs.

For services covered by Michigan Medicaid:

- The provider will bill Molina Dual Options for your services. Molina Dual Options will pay for the services covered by Michigan Medicaid. You pay nothing for these services.

Note: If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You can contact your Care Coordinator at (855) 735-5604, TTY: 711, Monday - Friday, 8:30 a.m. to 5 p.m., EST.

E2. Services covered by the Prepaid Inpatient Health Plan (PIHP)

The following services are covered by Molina Dual Options but are available through the Prepaid Inpatient Health Plan (PIHP) and its provider network.

Inpatient behavioral health care

- The plan will pay for behavioral health care services that require a hospital stay.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Outpatient substance use disorder services

- We will pay for treatment services that are provided in the outpatient department of a hospital if you, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or if you require treatment but do not require the level of services provided in the inpatient hospital setting.

Partial hospitalization services

- Partial hospitalization is a structured program of active psychiatric treatment. It is offered as 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.

Please see the separate PIHP Member Handbook for more information and work with your Care Coordinator to get services provided through the PIHP.

F. Benefits not covered by Molina Dual Options, Medicare, or Michigan Medicaid

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not pay for these benefits. Medicare and Michigan Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan, Medicare, or Michigan Medicaid:**

- Services considered not “reasonable and necessary,” according to the standards of Medicare and *Michigan* Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3, page 36 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 it is medically necessary and Medicare pays for it.
- A private room in a hospital or nursing facility, except when it is medically necessary.
- Private duty nurses except for those that qualify for this waiver service.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- 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, the plan will 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 Medicare 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 and LASIK surgery. However, the plan will pay for glasses after cataract surgery.
- Reversal of sterilization procedures*
- Gender Reassignment (Sex Change Operations)*
 - Unless the sex change operation is a medically necessary health care service that is evidence-based and provided within generally accepted standards of medical practice to prevent, diagnose or treat an illness, condition, disease or its symptoms.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.
- Elective abortions and related services
- Services for treatment of infertility



Chapter 5: Getting your outpatient prescription drugs through the plan

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 Michigan Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Molina Dual Options also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some 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, see the Benefits Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

The plan will 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. 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. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the 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.
 - See page 108 to learn about asking for an exception.
4. 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.



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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions **only** if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

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

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug. You may not be required to pay a copay.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, see Chapter 7.
- If you need help getting a prescription filled, you can contact your Care Coordinator or Member Services.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, 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 it has remaining refills.

If you need help changing your network pharmacy, you can contact your Care Coordinator or Member Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have 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 your Care Coordinator or Member Services.

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.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must 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 any difficulty accessing your drug benefits in a long-term care facility, please 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 supply drugs requiring special handling and instructions on their use.

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact your Care Coordinator or Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs that are not available through the 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 30-day supply of the drug and no more than a 90-day supply. A 90-day supply has no copay.

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST or you can visit www.MolinaHealthcare.com/Duals.

Usually, a mail-order prescription will get to you within 10 days. Please call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST if your mail-order is delayed.

Mail-order processes

The 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 will automatically fill and deliver new prescriptions it gets from you.

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

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

- This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped.
- It is important that you respond each time you are contacted by the pharmacy, 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 of your drugs, you have the option to sign up for an automatic refill program called the Auto Refill and Renewal Program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 10 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of the Auto Refill and Renewal Program that automatically prepares mail order refills, please contact us by calling Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. 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 no copay. 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 the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not 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 will 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, please check first with Member Services to see if there is a network pharmacy nearby.



A9. Paying you back if you pay for a prescription

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

To learn more about this, see Chapter 7.

B. The plan's Drug List

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs and items covered under your Michigan Medicaid benefits.

The Drug List includes both brand-name drugs, for example BYSTOLIC, and generic drugs, for example Metoprolol. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

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

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.MolinaHealthcare.com/Duals. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.
- Ask your Care Coordinator to find out if a drug is on the plan's Drug List.

B3. Drugs that are not on the Drug List

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Molina Dual Options will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay

for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Michigan Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Molina Dual Options for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Michigan Medicaid.

- 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 when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of three (3) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1 drugs are generic drugs. For Tier 1 drugs, you pay nothing
- Tier 2 drugs are brand name drugs. For Tier 2 drugs, you pay nothing.
- Tier 3 drugs are Non-Medicare Rx/Over-The-Counter (OTC) drugs. For Tier 3 drugs, you pay nothing.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

C. Limits on some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, 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 will work just as well as a higher-cost drug, the plans expects your provider to prescribe the lower-cost drug.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



If there is a special rule for your drug, it usually means that you or your provider will have to 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 think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, see Chapter 9.

What kinds of rules are there?

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, our network pharmacies will give you the generic version.

- We usually will not pay for the brand-name drug when there is a generic version.
- However, if your provider *has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will 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 Molina Dual Options before you fill your prescription. If you don't get approval, Molina Dual Options may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers 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, the plan may require you to try Drug A first.

If Drug A does not work for you, the plan will then 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, the plan might limit how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at www.MolinaHealthcare.com/Duals.



D. Reasons your drug might not be covered

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

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

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

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

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

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

For Medicare Part D Drugs:

- You were in the plan last year.
 - We will cover a temporary supply of your drug **during the first 90 days of the calendar year.**
 - This temporary supply will be for up to 60 days.
 - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 60 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 the plan.
 - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
 - This temporary supply will be for up to 60 days.
 - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 60 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 the plan for more than 90 days and live in a long-term care facility and need a supply right away.
 - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
 - If you are a new resident of a LTC facility and have been enrolled in our Plan for more than 90 days and need a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the member pursues a formulary exception. Exceptions are available in situations where you experience a change in the level of care you are receiving that also requires you to transition from one facility or treatment center to another. In such circumstances, you would be eligible for a temporary, one-time fill exception even if you are outside of the first 90 days as a member of the plan. Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't 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.

For Michigan Medicaid drugs:

- You are new to the plan.
 - We will cover a supply of your Michigan Medicaid drug for up to 90 calendar days after enrollment and will not terminate it at the end of the 90 calendar days without advance notice to you and a transition to another drug, if needed.
 - To ask for a temporary supply of a drug, call Member Services.

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

- You can change to another drug.

There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- You can ask for an exception.

You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.



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

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will 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, see Chapter 9.

If you need help asking for an exception, you can contact your Care Coordinator or Member Services.

E. Changes in coverage for your drugs

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

- Decide to require or not require prior approval for a drug. (Prior approval is permission from Molina Dual Options before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, see Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally 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 the 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 the Drug List changes, you can always:

- Check Molina Dual Options' up to date Drug List online at www.MolinaHealthcare.com/Duals or
- Call Member Services to check the current Drug List at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST.

Some changes to the Drug List will 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 the 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 will stay 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 will 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 will send you a notice with the steps you can take to ask for an exception. Please see Chapter 9 of this 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 will take it off the Drug List. If you are taking the drug, we will let you know. Contact your prescribing doctor if you receive a notification.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the 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 the Drug List **or**
 - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

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

This will give you time to talk to your doctor or other prescriber. He or she can help you decide:

- If there is a similar drug on the Drug List you can take instead or
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, see Chapter 9.

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug 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**.

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

F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

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



F2. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living 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, please contact Member Services.

F3. If you are in a Medicare-certified hospice program

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

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, 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 should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, see Chapter 4.

G. Programs on drug safety and managing drugs

G1. Programs to help members 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 are taking 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 may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions, 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 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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

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. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, 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 that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

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

G3. Drug management program to help members safely use their opioid medications

Molina Dual Options has a program that can help members safely use their prescription opioid medications or other medications that are frequently abused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. Limitations may include:

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

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

You will have a chance to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake, you disagree that you are at risk for prescription drug abuse, or you disagree with the limitation, you and your prescriber can file an appeal. (To learn how to file an appeal, see Chapter 9.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer,
- are getting hospice, palliative, or end-of-life care, **or**

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- live in a long-term care facility.



Chapter 6: What you pay for your Medicare and Michigan Medicaid 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 Michigan Medicaid, **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Michigan Medicaid, you are getting “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 the *Member Handbook*.

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

- The plan’s *List of Covered Drugs*.
 - We call this the “Drug List.” It tells you:
 - Which drugs the plan pays for
 - Which of the three (3) tiers each drug is in
 - Whether there are any limits on the drugs
 - If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at www.MolinaHealthcare.com/Duals. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.
 - Chapter 5 tells how to get your outpatient prescription drugs through the plan.
 - It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- The plan’s *Provider and Pharmacy Directory*.
 - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
 - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.



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A. The *Explanation of Benefits (EOB)*

Our plan keeps track of your prescription drugs. We keep track of your total drug costs. This includes the amount of money the plan pays (or others on your behalf pay) for your prescriptions.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits*. We call it the EOB for short. The EOB includes:

- **Information for the month.** The report tells what prescription drugs you got. It shows the total drug costs and what the plan paid, and what others paying for you paid.
- **“Year-to-date” information.** This is your total drug costs and the total payments made for you since January 1.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your Part D total out-of-pocket costs.
- To find out which drugs our plan covers, see the Drug List.

B. How to keep track of your drug costs

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

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill.

2. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your total 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.

3. Check the reports we send you.

When you get an *Explanation of Benefits* in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

C. A summary of your drug coverage

As a Molina Dual Options member, you pay nothing for covered prescription and over-the-counter (OTC) drugs as long as you follow Molina Dual Options' rules.

C1. The plan's tiers

Tiers are groups of drugs. Every drug on the plan's Drug List is in one of three (3) tiers. There is no cost to you for drugs on any of the tiers.

- Tier 1 drugs are generic drugs. For Tier 1 drugs, you pay nothing.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- Tier 2 drugs are brand name drugs. For Tier 2 drugs, you pay nothing.
- Tier 3 drugs are Non-Medicare Rx/Over-The-Counter (OTC) drugs. For Tier 3 drugs, you pay nothing.

C2. 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. There is no cost to you for a long-term supply.

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

C3. Drug coverage summary

Your coverage for a one-month or long-term supply of a covered prescription drug

	A network pharmacy A one-month or up to a 90-day supply	The plan’s mail-order service A one-month or up to a 90-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. See Chapter 5 for details.
Tier 1 (generic drugs)	\$0	\$0	\$0	\$0
Tier 2 (brand name drugs)	\$0	\$0	\$0	\$0
Tier 3 (Non-Medicare Rx/Over-The-Counter (OTC) drugs)	\$0	\$0	\$0	\$0

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

D. Vaccinations

Our plan covers Medicare Part D vaccines. You will not have to pay for vaccines if you get the vaccine through an in-network provider. 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.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



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.

D1. What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with Molina Dual Options to ensure that you do not have any upfront costs for a Part D vaccine.



Chapter 7: Asking us to pay a bill you have gotten for covered 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 the *Member Handbook*.

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A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A *network provider* is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, see page 142.

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

Contact Member Services or your Care Coordinator *if* you have any questions. If you get a bill and you do not 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 our plan 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

You should ask the provider to bill the plan.

- 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 do not 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 have already paid for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill the plan. Show your Molina Dual Options Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills you do not understand.**

- Because Molina Dual Options pays 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 have 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 go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Please see Chapter 5 to learn more about out-of-network pharmacies.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
 - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9).
 - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

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

To learn how to make an appeal, see Chapter 9.

B. Sending a request for payment

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

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

For Medical Services and Medicaid Drugs:

Molina Dual Options
Attn: Appeals & Grievances
880 W. Long Lake Rd., Suite 600
Troy, MI 48098

For Part D (Rx) Services:

Molina Dual Options
7050 Union Park Center, Suite 200
Midvale, UT 84047

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



You must submit your claim to us within 36 months of the date you got the drug.

C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will 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 have not paid for the service or drug yet, we will pay the provider directly.

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

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, see Chapter 9.

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 an appeal. You can also make an appeal if you do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9.

- If you want to make an appeal about getting paid back for a health care service, go to page 142.
- If you want to make an appeal about getting paid back for a drug, go to page 143.



Chapter 8: Your rights and responsibilities

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

We must tell you about the 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 at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST or your Care Coordinator at (855) 735-5604, TTY: 711, Monday - Friday, 8:30 a.m. to 5 p.m., EST. Our plan has people who can answer questions in different languages
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio.
- 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) 642-3195, TTY: 711, Monday – Friday, 8 a.m. to 7 p.m., EST to update your record with the preferred language. To get this document in an alternate format, please contact Member Services at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. A representative can help you make or change a standing request. You can also contact your Care Coordinator for help with standing requests.
- If you are having 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, seven days a week. TTY users should call 1-877-486-2048. You may also file a complaint with Michigan Medicaid. Please see Chapter 9 for more information.

A. Usted tiene derecho a recibir información de una manera que cumpla con sus necesidades

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

- Para obtener información en una manera que pueda entender, comuníquese con el Departamento de Servicios para Miembros al (855) 735-5604, TTY al 711, de lunes a viernes, de 8:00 a. m. a 8:00 p. m., EST; o bien, comuníquese con su Coordinador de Cuidados al (855) 735-5604, TTY al 711, de lunes a viernes a viernes, de 8:30 a. m. a 5:00 p. m., EST. Nuestro plan de salud cuenta con personal que puede contestar preguntas en diferentes idiomas.
- Nuestro plan también le puede ofrecer materiales en otros idiomas aparte de inglés y en formatos como letra grande, braille o audio. Por favor comuníquese con el Departamento de Servicios para Miembros al (855) 735-5604, TTY al 711, de lunes a viernes, de 8:00 a. m. a 8:00 p. m., EST, para solicitar materiales en un formato alternativo.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- 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) 642-3195, TTY: 711, de lunes a viernes, de 8.00 a. m. a 5.00 p. m., EST) 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) 735-5604, TTY: 711, de lunes a viernes, de 8.00 a. m. a 8.00 p. m., EST. 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 dificultades para obtener información de nuestro plan de salud debido a problemas de idioma o una discapacidad y desea presentar una queja, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Usted puede llamar las 24 horas al día, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede presentar una queja con Michigan Medicaid. Por favor, consulte Capítulo 9 para más información.

A. يحق لك الحصول على المعلومات بطريقة تلي احتياجاتك.

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

- للحصول على معلومات بطريقة تستطيع استيعابها، قم بالاتصال بقسم خدمات الأعضاء على الرقم (855) 735-5604، وبالنسبة لمستخدمي أجهزة الهواتف النسيبة: يمكن الاتصال على الرقم 711 من الإثنين إلى الجمعة، من الساعة 8 صباحًا إلى 8 مساءً حسب التوقيت الشرقي القياسي، أو بمنسق الرعاية الخاص بك على الرقم (855) 735-5604، ولمستخدمي أجهزة الهواتف النسيبة: يمكنهم الاتصال على الرقم 711، من الإثنين إلى الجمعة من الساعة 8:30 صباحًا إلى 5 مساءً، حسب التوقيت الشرقي القياسي. إن خطتنا تضم أفرادًا بمقدورهم الإجابة عن الأسئلة بلغات مختلفة.
- كما يمكن أن توفر لك الخطة مواد بلغات غير الإنجليزية وبتنسيقات مثل المطبوعات الكبيرة أو بطريقة برايل أو بالتنسيق الصوتي.
- يمكنك أن تطلب منا أن نرسل لك المعلومات دائمًا باللغة أو التنسيق الذي تحتاجه. ويسمى هذا طلبًا مستمرًا. وسوف نتابع 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) 642-3195، وبالنسبة لمستخدمي أجهزة الهواتف النسيبة: 711، من الإثنين إلى الجمعة، من الساعة 8 صباحًا حتى 7 مساءً بالتوقيت الشرقي القياسي لتحديث السجل الخاص بك باللغة المفضلة. للحصول على هذه الوثيقة بتنسيق بديل، يرجى الاتصال بقسم خدمات الأعضاء على الرقم (855) 735-5604، ولمستخدمي أجهزة الهواتف النسيبة / أجهزة الاتصالات الكتابية للصم والبكم: 711، من الإثنين إلى الجمعة، من 8 صباحًا وحتى 8 مساءً، بالتوقيت الشرقي القياسي. ويمكن لأحد المندوبين مساعدتك في تقديم طلب مستمر أو تغييره. كما يمكنك الاتصال بمنسق الرعاية الخاصة بك لمساعدتك بشأن تقديم طلبات مستمرة.
- إذا واجهت صعوبة في الحصول على معلومات من خطتنا بسبب مشاكل تتعلق باللغة أو إعاقة ما وتود تقديم شكوى بهذا الشأن، فالرجاء الاتصال ببرنامج Medicare على الرقم (1-800-633-4227) 1-800-MEDICARE. يُمكنك الاتصال بنا على مدار 24 ساعة في اليوم، 7 أيام في الأسبوع. بالنسبة لمستخدمي أجهزة الهواتف النسيبة، يرجى الاتصال على الرقم 1-877-486-2048 كما يحق لك كذلك التقدم بشكوى ضد Michigan Medicaid. يُرجى الاطلاع على الفصل التاسع لمعرفة المزيد من المعلومات.

B. Our responsibility to ensure that you get timely access to covered services and drugs

If you have a hard time getting care, contact Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. If you are having trouble getting services within a reasonable amount of

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. For more information, visit

www.MolinaHealthcare.com/Duals.



time, we will work with you to refer you to another provider. If necessary, we may also refer you for out-of-network care if we cannot provide the service within our network.

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You also have the right to change the PCP within your health plan. You can find more information about choosing a PCP in Chapter 3.
 - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to go to a women's health specialist without getting a referral. A referral is approval from your PCP to see someone 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 services from specialists.
- 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 see an out-of-network provider. To learn about out-of-network providers, see Chapter 3.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have 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 the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

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

C1. How we protect your PHI

We make sure that unauthorized people do not see or change your records.

In most situations, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- We are required to give Medicare and Michigan Medicaid your PHI. If Medicare or Michigan Medicaid releases your information for research or other uses, it will be done according to Federal and State laws.

C2. You have a right to see your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a reasonable fee for making a copy of your medical records.

You have the right to amend or correct information in your medical records. The correction will become part of your record.

You have the right to know if and how your PHI has been shared with others.

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

Your Privacy

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) 735-5604, Monday - Friday, 8 a.m. to 8 p.m. EST. TTY users, please call 711.

**NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF MICHIGAN**

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 Michigan ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") uses and shares protected health information about you to provide your health benefits as a Molina Dual Options 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 February 1, 2014.

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

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



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.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



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.

Victims of Abuse, Neglect or Domestic Violence

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

Workers Compensation

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

Other Disclosures

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

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

Molina needs your written approval to use or share your PHI for a purpose other than those listed in this Notice. Molina needs your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**

You may ask us not to share your PHI to carry out treatment, payment or health care operations.

You may also ask us not to share your PHI with family, friends or other persons you name who are



involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request.

- **Request Confidential Communications of PHI**

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

- **Review and Copy Your PHI**

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Member. You will need to make your request in writing. You may use Molina's form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request. *Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.*

- **Amend Your PHI**

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a Member. You will need to make your request in writing. You may use Molina's form to make your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with your authorization;
- 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.

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

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Molina Member Services at (855) 735-5604, Monday - Friday, 8 a.m. to 8 p.m. EST. 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:

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Molina Healthcare of Michigan
Attention: Director of Member Services
880 W. Long Lake Road, Suite 600
Troy, MI 48098

Phone: (855) 735-5604, Monday - Friday, 8 a.m. to 8 p.m. EST. TTY users, please 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 515F, HHH Building
(800) 368-1019; (800) 537-7697;
(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:

Molina Healthcare of Michigan
Attention: Director of Member Services
880 W. Long Lake Road, Suite 600
Troy, MI 48098

Phone: (855) 735-5604, Monday - Friday, 8 a.m. to 8 p.m. EST. TTY users, please call 711

D. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of Molina Dual Options, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



This is a free service. Our plan also has written materials available in Spanish and Arabic. 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) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

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

- How to choose or change plans
- Our plan, including:
 - Financial information
 - How the plan has been rated by plan members
 - The number of appeals made by members
 - How to leave the 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
 - For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at www.MolinaHealthcare.com/Duals.
- Covered services and drugs and about rules you must follow, including:
 - Services and drugs covered by the 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, 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 charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7.



F. Your right to leave the 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 a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- See Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- If there is another MI Health Link plan in your service area, you may also change to a different MI Health Link plan and continue to get coordinated Medicare and Michigan Medicaid benefits.
- You can get your Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. 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 all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told 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 see 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 also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the 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 has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask the plan for a coverage decision.



G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

You may call Molina Dual Options to get information regarding State law on Advance Directives and changes to Advance Directive laws.

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

- Fill out a written form to **give someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can 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 psychiatric advance directive and a durable power of attorney for health care.

Now is a good time to write down your advance directives because you can make your wishes known while you are healthy. Your doctor's office has an advance directive you fill out to tell your doctor what you want done. Your advance directive often includes a do-not-resuscitate order. Some people do this after talking to their doctor about their health status. It gives written notice to health care workers who may be treating you should you stop breathing or your heart stops. Your doctor can help you with this if you are interested.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Michigan Medicaid may also have advance directive forms. You can also contact Member Services to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

G3. What to do if your instructions are not followed

In Michigan, your advance directive has binding effect on doctors and hospitals. However, if you believe that a doctor or a hospital did not follow the instructions in your advance directive, you may file a complaint

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services at 1-800-882-6006.

H. Your right to make complaints and to ask us to reconsider decisions we have made

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

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights.

If you believe you have been treated unfairly — and it is **not** about discrimination for the reasons listed on page 175 — or you would like more information about your rights, you can get help by calling:

- Member Services.
- The State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Medicare/Medicaid Assistance Program (MMAAP). For details about this organization and how to contact it, see Chapter 2.
- 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.” (Go to,” found on the Medicare website at <https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf>.)
- The MI Health Link Ombudsman program. The phone number for the MI Health Link Ombudsman program is 1-888-746-6456, Monday - Friday, 8:30 a.m. to 5 p.m., EST.

I. Your responsibilities as a member of the plan

As a member of the plan, 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 is covered and what rules you need to follow to get covered services and drugs. For details about your:
 - Covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
 - Covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- **Help your doctors** and other health care providers give you the best care.
 - Give them the 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 are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - Medicare Part A and Medicare Part B premiums. For almost all Molina Dual Options members, Michigan Medicaid pays for your Part A premium and for your Part B premium.
 - The Patient Pay Amount (PPA) is the amount of money you may be asked to pay for the time you stay in a nursing home based on your income and set by the state. When your income exceed an allowable amount, you must contribute toward the cost of your nursing facility care. The PPA contribution is required if you live in a nursing facility. Chapter 4 provides additional information about the Patient Pay Amount (PPA) for nursing facility services.
 - Any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.
 - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.**
 - If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
 - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Molina Dual Options. Chapter 1 tells about our service area.
 - We can help you figure out whether you are 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 let you know if we have a plan in your new area.
 - Also, be sure to let Medicare and Michigan Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and Michigan Medicaid.
 - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.



- Call Member Services for help if you have questions or concerns.
- Enrollees age 55 and older who are getting long term care services may be subject to estate recovery upon their death. For more information, you may:
 - Contact your Care Coordinator, **or**
 - Call the Beneficiary Helpline at 1-800-642-3195, **or**
 - Visit the website at michigan.gov/estaterecovery, **or**
 - Email questions to MDHHS-EstateRecovery@michigan.gov



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

What's in this chapter?

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 has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

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

If you are facing a problem with your health or long term supports and services

You should get the health care, drugs, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your care plan. You should try to work with your providers and Molina Dual Options first. **If you are still having a problem with your care or our plan, you can call the MI Health Link Ombudsman at 1-888-746-6456.** This chapter explains the different options you have for different problems and complaints, but you can always call the MI Health Link Ombudsman to help guide you through your problem. For additional resources to address your concerns and ways to contact them, see Chapter 2 for more information on ombudsman programs.



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Section 1: Introduction

• Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Michigan Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

• Section 1.2: What about the legal terms?

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

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

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

Section 2: Where to call for help

• Section 2.1: Where to get more information and help

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

You can get help from the MI Health Link Ombudsman

If you need help getting answers to your questions or understanding what to do to handle your problem, you can call the MI Health Link Ombudsman. The MI Health Link Ombudsman is not connected with us or with any insurance company. They can help you understand which process to use. The phone number for the MI Health Link Ombudsman is 1-888-746-6456. The services are free. See Chapter 2 for more information on ombudsman programs.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). In Michigan the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP counselors can answer your questions and help you understand what to do to handle your problem. MMAP is not connected with us or with any insurance company or health plan. MMAP has trained counselors and their services

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



are free. The MMAP phone number is 1-800-803-7174. You can also find information on MMAP's website at <http://mmapinc.org>.

Getting help from Medicare

You can call Medicare directly for help with problems. 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: 1-877-486-2048. The call is free.
- Visit the Medicare website (<http://www.medicare.gov>).

Getting help from Michigan Medicaid

You can also call Michigan Medicaid for help with problems. Call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet based phone service.

Livanta is the Michigan Quality Improvement Organization (QIO) who can provide assistance if you believe you are being discharged too soon. Call Livanta at 1-888-524-9900, Monday – Friday, 9 a.m. to 5 p.m.; Saturdays, Sundays, and Holidays, 11 a.m. to 3 p.m. (TTY: 1-888-985-8775).

Section 3: Which process to use to help with your problem

- **Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?**

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help 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, long term supports and services, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care, long term supports and services, or prescription drugs.)

<p>Yes.</p> <p>My problem is about benefits or coverage.</p> <p>Go to Section 4: “Coverage decisions and appeals” on page 128.</p>	<p>No.</p> <p>My problem is not about benefits or coverage.</p> <p>Skip ahead to Section 10: “How to make a complaint” on page 163.</p>
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Section 4: Coverage decisions and appeals

• Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

NOTE: Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about coverage decisions and appeals on behavioral health services. If you reside in Wayne County, including Detroit residents, you will contact the Detroit Wayne Integrated Health Network. Call 1-313-344-9099 (TTY: 1-800-630-1044). If you reside in the Macomb County, you will contact Macomb County Community Mental Health. Call 1-855-996-2264 (TTY: 711).

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. We are also making a coverage decision whenever you ask us to increase or change the amount of a service, item, or drug that you are already receiving.

If you or your providers are not sure if a service, item, or drug is covered by Medicare or Michigan Medicaid, either of you can ask for a coverage decision before you get the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is not medically necessary for you. If you or your provider disagree with our decision, you can appeal.

• Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call your **Care Coordinator** at (855) 735-5604, TTY: 711, Monday - Friday, 8:30 a.m. to 5 p.m., EST.
- Call **Member Services** at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Call the **MI Health Link Ombudsman** for free help. The MI Health Link Ombudsman can help you with questions about or problems with MI Health Link or our plan. The MI Health Link Ombudsman is an independent program, and is not connected with this plan. The phone number is 1-888-746-6456.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- Call the **Michigan Medicare/Medicaid Assistance Program (MMAP)** for free help. MMAP is an independent organization. It is not connected with this plan. The phone number is 1-800-803-7174.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal. Your designated representative will have the same rights as you do in asking for a coverage decision or making an appeal.
 - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form.
 - You can also get the form by visiting <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at www.MolinaHealthcare.com/Duals. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you choose to have a lawyer, you must pay for those legal services. However, some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
 - However, you do not need a lawyer to ask for any kind of coverage decision or to make an appeal.

• **Section 4.3: Which section of this chapter will help you?**

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section 5 on page 130** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
 - You are not getting medical care or other supports and services that you want, and you believe our plan covers this care.
 - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered and is medically necessary.
 - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with a (*) are not covered by Part D. See Section 6 on page 143 for Part D drug appeals.
 - You got medical care or other supports and services you think should be covered, but we are not paying for this care.
 - You got and paid for medical care or other supports and services you thought were covered, and you want to ask us to pay you back.
 - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.



- **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages 151 and 157.
- **Section 6 on page 143** gives you information about Part D drugs. For example, use this section if:
 - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
 - You want to ask us to waive limits on the amount of the drug you can get.
 - You want to ask us to cover a drug that requires prior approval.
 - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
 - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section 7 on page 151** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
 - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8 on page 157** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call your Care Coordinator at (855) 735-5604, TTY 711, Monday - Friday, 8:30 a.m. to 5 p.m., EST or Member Services at (855) 735-5604, TTY 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

If you need other help or information, please call the MI Health Link Ombudsman at 1-888-746-6456.

Section 5: Problems about services, items, and drugs (not Part D drugs)

• Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical care or other supports and services. You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B Drugs. Drugs in the Drug List with a (*) are **not** covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. **You think we cover a medical service or other supports and services you need but are not getting.**

What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 131 for information on asking for a coverage decision.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



2. We did not approve care your provider wants to give you, and you think we should have.

What you can do: You can appeal our decision to not approve the care. Go to Section 5.3 on page 133 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

What you can do: You can appeal our decision not to pay. Go to Section 5.3 on page 133 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

What you can do: You can ask us to pay you back. Go to Section 5.5 on page 142 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

What you can do: You can appeal our decision to reduce or stop the service. Go to Section 5.3 on page 133 for information on making an appeal.

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 151 and 157 to find out more.

• **Section 5.2: Asking for a coverage decision**

How to ask for a coverage decision to get medical care or long term supports and services (LTSS)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: (855) 735-5604 TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST
- You can fax us at: (888) 295-7665
- You can write to us at: Molina Dual Options 80 West Long Lake Road, Suite 600 Troy, MI 48098

NOTE: Your Prepaid Inpatient Health Plan (PIHP) will make coverage decisions for behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information. If you reside in Wayne County, including Detroit residents, you will contact the Detroit Wayne Integrated Health Network. Call 1-313-344-9099 (TTY: 1-800-630-1044). If you reside in the Macomb County, you will contact Macomb County Community Mental Health. Call 1-855-996-2264 (TTY: 711).

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you, your representative, or your provider asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a “fast coverage decision.” If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

The legal term for “fast coverage decision” is “expedited determination.”

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST or fax us at (888) 295-7665. For details on how to contact us, go to Chapter 2.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision only if you are asking about coverage for services or items you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you already got.)
2. You can get a fast coverage decision only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.
 - If your provider says that you need a fast coverage decision, we will automatically give you one.
 - If you ask for a fast coverage decision without your provider's support, we will decide if you get a fast coverage decision.
 - If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
 - This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell 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 the process for making complaints, including fast complaints, see Section 10 on page 163.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



How will I find out the plan's answer about my coverage decision?

We will send you a letter telling you whether or not we approved coverage.

If the coverage decision is Yes, when will I get the service or item?

You will be approved (pre-authorized) to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked unless your request is for a Medicare Part B prescription drug.

- If your request is for a Medicare Part B prescription drug, you will be approved (pre-authorized) to get the drug within 72 hours (for a standard coverage decision) or 24 hours (for a fast coverage decision).
- If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period. We can't take extra time to make our coverage decision for a Medicare Part B prescription drug.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to the Internal Appeals process (read the next section for more information).

• **Section 5.3: Internal Appeal for services, items, and drugs (not Part D drugs)**

What is an appeal?

An appeal is a formal way of asking us to review a coverage decision (denial) or any adverse action that we took. If you or your provider disagree with our decision, you can appeal.

NOTE: Your Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information. If you reside in Wayne County, including Detroit residents, you will contact the Detroit Wayne Integrated Health Network. Call 1-313-344-9099 (TTY: 1-800-630-1044). If you reside in the Macomb County, you will contact Macomb County Community Mental Health. Call 1-855-996-2264 (TTY: 711).

If you need help during the appeals process, you can call the MI Health Link Ombudsman at 1-888-746-6456. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan.

What is an adverse action?

An adverse action is an action, or lack of action, by our plan that you can appeal. This includes:

- We denied or limited a service or item your provider requested;
- We reduced, suspended, or ended coverage that was already approved;

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- We did not pay for a service or item that you think is covered;
- We did not resolve your authorization request within the required timeframes;
- You could not get a covered service or item from a provider in our network within a reasonable amount of time; or
- We did not act within the timeframes for reviewing a coverage decision and giving you a decision.

What is an Internal Appeal?

An Internal Appeal (also called a Level 1 Appeal) is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing and tell you what you can do next if you disagree with the decision.

You must ask for an Internal Appeal before you can ask for an External Appeal under Section 5.4 below.

You can ask for a “standard appeal” or a “fast appeal.”

How do I make an Internal Appeal?

- To start your appeal, you, your representative, or your provider must contact us. You can call us at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. For additional details on how to reach us for appeals, see Chapter 2.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
 - You can submit a request to the following address:
Molina Dual Options
Attn: Grievance and Appeals Dept.
P.O. Box 22816
Long Beach, CA 90801-9977
 - You may also ask for an appeal by calling us at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

At a glance: How to make an Internal Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

The legal term for “fast appeal” is “expedited reconsideration..”

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you. First, you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or our website at www.MolinaHealthcare.com/Duals.

We must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an Internal Appeal?

You must ask for an Internal Appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you were in the hospital, or we gave you the wrong information about the deadline for requesting an appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Internal Appeals” on page 167 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

Can my provider give you more information about my appeal?

Yes. Both you and your provider may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care or other supports and services. Then, we check to see if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.



When will I hear about a “standard” appeal decision?

We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 163.
- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Michigan Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 on page 137.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we automatically sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Michigan Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 on page 137.

When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your condition requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 163.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Michigan Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 on page 137.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Michigan Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 on page 137.

Will my benefits continue during Internal Appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the proposed action. If you file your Internal Appeal within 10 calendar days of the date on our notice or prior to the intended effective date of the action, we will continue your benefits for the service while the Internal Appeal is pending.

If you are appealing to get a new service from our plan, then you would not get that service unless your appeal is finished and the decision is that the service is covered.

• Section 5.4: External Appeal for services, items, and drugs (not Part D drugs)

If the plan says No to the Internal Appeal, what happens next?

You must ask for an Internal Appeal and get a decision from us before you can ask for an External Appeal.

If we say **No** to part or all of your Internal Appeal, we will send you an appeal denial notice. This notice is called the Notice of Appeal Decision. This notice will tell you if the service or item is usually covered by Medicare and/or Michigan Medicaid.

- If your problem is about a Medicare service or item, you will automatically get an External Appeal with the Independent Review Entity (IRE) as soon as the Internal Appeal is complete.
- If your problem is about a Michigan Medicaid service or item, you can file an External Appeal yourself with the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or a request for an External Review with the Michigan Department of Insurance and Financial Services (DIFS). The Notice of Appeal Decision will tell you how to do this. Information is also on page 137.
- If your problem is about a service or item that could be covered by both Medicare and Michigan Medicaid, you will automatically get an External Appeal with the IRE. You can also ask for an External Appeal with MOAHR and/or External Review with DIFS.

What is an External Appeal?

An External Appeal (also called a Level 2 Appeal) is the second appeal, which is done by an independent organization that is not connected to the plan. Medicare's External Appeal organization is called the Independent Review Entity (IRE). Michigan Medicaid's External Appeal is a Fair Hearing through the Michigan Office of Administrative Hearings and Rules (MOAHR). You also have the right to request an External Review of Michigan Medicaid service denials through the Michigan Department of Insurance and Financial Services (DIFS).

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



My problem is about a Michigan Medicaid covered service or item. How can I make an External Appeal?

There are two ways to make an External Appeal for Michigan Medicaid services and items: (1) Fair Hearing and/or (2) External Review.

1. Fair Hearing

You have the right to ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR). A Fair Hearing is an impartial review of a decision made by our plan. You may ask for a Fair Hearing after the Internal Appeal with our plan. In addition, if you do not receive a notice about your appeal, or a decision on your appeal within the time frame the plan has to respond on your appeal, you may ask for a Michigan Medicaid Fair Hearing.

You must ask for a Fair Hearing **within 120 calendar days** from the date on the Notice of Appeal Decision.

NOTE: If you ask for a Fair Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to file your request** if you want to keep getting that service while your Fair Hearing is pending. Read “Will my benefits continue during External Appeals” on page 137 for more information.

To ask for a Fair Hearing from MOAHR, you must complete a Request for Hearing form. We will send you a Request for Hearing form with the Notice of Appeal Decision. You can also get the form by calling the Michigan Medicaid Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service, Monday through Friday from 8:00 AM to 7:00 PM. Complete the form and send it to:

Michigan Office of Administrative Hearing and Rules (MOAHR)
Department of Health and Human Services
PO Box 30763
Lansing, MI 48909
FAX: 517-763-0146

You can also ask for an expedited (fast) Fair Hearing by writing to the address or faxing to the number listed above.

After MOAHR gets your Fair Hearing request, you will get a letter telling you the date, time, and place of your hearing. Hearings are usually conducted over the phone, but you can ask that your hearing be conducted in person.

MOAHR must give you an answer in writing within 90 calendar days of when it gets your request for a Fair Hearing. If you qualify for an expedited Fair Hearing, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

After you get the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court.



2. External Review

You also have the right to ask for an External Review through the Michigan Department of Insurance and Financial Services (DIFS). You must complete our Internal Appeals process first before you can ask for this type of External Appeal.

Your request for an External Review must be submitted **within 127 calendar days** of your receipt of our Internal Appeal decision.

NOTE: If you qualified for continuation of benefits during the Internal Appeal and you ask for an External Review **within 10 calendar days** from the date of the Internal Appeal decision, you can continue to get the disputed service during the review. Read “Will my benefits continue during External Appeals” on page 137 for more information.

To ask for an External Review from DIFS, you must complete the Health Care Request for External Review form. We will send you this form with our Notice of Appeal Decision. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to:

DIFS - Office of General Counsel
Health Care Appeals Section
PO Box 30220
Lansing, MI 48909-7720
FAX: 517-284 8838
DIFS Consumer Hotline: 877-999-6442

If your request does not involve reviewing medical records, the External Review will be conducted by the Director of DIFS. If your request involves issues of medical necessity or clinical review criteria, it will be sent to a separate Independent Review Organization (IRO).

If the review is conducted by the Director and does not require review by an IRO, the Director will issue a decision within 14 calendar days after your request is accepted. If the review is referred to an IRO, the IRO will give its recommendation to DIFS within 14 calendar days after it is assigned the review. The Director will then issue a decision within 7 business days after it receives the IRO's recommendation.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited (fast) review. An expedited review is completed within 72 hours after your request. To qualify for an expedited review, you must have your doctor verify that the timeframe for a standard review would jeopardize your life or health.

If you disagree with the External Review decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision.

My problem is about a Medicare covered service or item. What will happen at the External Appeal?

An Independent Review Entity (IRE) will carefully review the Internal Appeal decision and decide whether it should be changed.

- You do not need to ask for the External Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be told when this happens.
- The IRE is hired by Medicare and is not connected with this plan.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- You may ask for a copy of your file by calling Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

The IRE must give you an answer to your External Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at the Internal Appeal, you will automatically have a fast appeal at the External Appeal. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item is covered by both Medicare and Michigan Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Michigan Medicaid, we will automatically send your External Appeal to the Independent Review Entity. You can also submit an External Appeal to the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or an External Review to the Michigan Department of Insurance and Financial Services (DIFS). Follow the instructions on page 137.

Will my benefits continue during External Appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization expired, you can continue your benefits during External Appeals in some cases.

- If the service is covered by Medicare *and* you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the External Appeal process with the Independent Review Entity (IRE).
- If the service is covered by Michigan Medicaid, your benefits for that service will continue if you qualified for continuation of benefits during your Internal Appeal and you ask for a Fair Hearing from MOAHR or an External Review from (DIFS) within 10 calendar days from the date of *the Notice of Appeal Decision*.
- If the service could be covered by both Medicare and Michigan Medicaid and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the IRE review. You may also qualify for continuation of benefits during MOAHR and/or DIFS review if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; or (2) all entities that got your appeal (the IRE, MOAHR, and/or DIFS) decide "no" to your request. If any of the entities decide "yes" to your request, your services will continue.



How will I find out about the decision?

If your External Appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision.

- If MOAHR says **Yes** to part or all of what you asked for, we must approve the service for you as quickly as your condition requires, but no later than 72 hours from the date we receive MOAHR's decision.
- If MOAHR says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called “upholding the decision” or “turning down your appeal.”

If your External Appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision.

- If MOAHR says **Yes** to part or all of what you asked for, we must approve the service for you as quickly as your condition requires.
- If DIFS says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called “upholding the decision” or “turning down your appeal.”

If your External Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for, we must authorize the coverage as quickly as your condition requires, but no later than 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called “upholding the decision.” It is also called “turning down your appeal.”

What if I had different types of External Appeals and they have different decisions?

If any of the External Appeal organizations (MOAHR, DIFS, and/or the IRE) decide **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If your External Appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, you can appeal the decision within 30 days to the Circuit Court. You may also request a rehearing or reconsideration by MOAHR within 30 days.

If your External Appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, you can appeal to the Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision.

If your External Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount.

The letter you get from the MOAHR, DIFS, or IRE will explain additional appeal rights you may have. See Section 9 on page 199 for more information on additional levels of appeal.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



NOTE: Your benefits for the disputed service will not continue during the additional levels of appeal.

• **Section 5.5: 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 any required Patient Pay Amount (PPA) for nursing home care.

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.

For more information, start by reading Chapter 7: “Asking us to pay a bill you have gotten for covered services or drugs.” Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see 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 the payment for the service or item within 60 calendar days after we get your request. 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 will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal.** Follow the appeals process described in Section 5.3 on page 133. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE 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 review by the IRE, we must send the payment you asked for to you or to the provider within 60 calendar days.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 on page 162 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Michigan Medicaid, you can ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) or an External Review from the Michigan Department of Insurance and Financial Services (see Section 5.4 on page 137).

Section 6: Part D drugs

• Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Michigan Medicaid may cover. **This section only applies to Part D drug appeals.**

The Drug List, includes some drugs with a (*). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with (*) symbol follow the process in Section 5 on page 130.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
 - Asking us to cover a Part D drug that is not on the plan’s Drug List,
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the 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 cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

The legal term for a coverage decision about your Part D drugs is “**coverage determination.**”

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 on page 144. Also see Sections 6.3 and 6.4 on pages 145 and 146.	You can ask us for a coverage decision. Skip ahead to Section 6.4 on page 146.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 6.4 on page 146.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 6.5 on page 148.

• **Section 6.2: What is an exception?**

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List
 - If we agree to make an exception and cover a drug that is not on the Drug List, you will not be charged.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5).
 - The extra rules and restrictions on coverage for certain drugs include:
 - Being required to use the generic version of a drug instead of the brand name drug.
 - Getting plan approval 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 will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
 - Quantity limits. For some drugs, we limit the amount of the drug you can have.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

• **Section 6.3: Important things to know about asking for exceptions**

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 requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, 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 request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 on page 148 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.



• **Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception**

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section 4 on page 128 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor’s statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor’s statement.



The legal term for “fast coverage decision” is “expedited coverage determination.”

You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.**

If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether you get a fast coverage
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
 - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
 - You can file a “fast complaint” and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 163.

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor’s or prescriber’s statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor’s or prescriber’s supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor’s or prescriber’s supporting statement.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

• Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan “redetermination.”

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 on page 146.

The legal term for “fast appeal” is “expedited redetermination.”

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and how to appeal our decision.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a “fast appeal.”
- If we do not give you a decision within 7 calendar days, or 14 days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.



- **If our answer is Yes** to part or all of what you asked for:
 - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 days if you asked us to pay you back for a drug you already bought.
 - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

• Section 6.6: Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

The legal term for an appeal to the IRE about a Part D drug is “**reconsideration**.”

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a “fast appeal.”

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

Section 7: Asking us to cover a longer hospital stay

When you are 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.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

• Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights”. If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at (855) 735-5604, TTY: 711, Monday

– Friday, 8 a.m. to 8 p.m., EST. 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.

Read this notice carefully and ask questions if you don't understand. The "Important Message" 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 are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. 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. The call is free.
- You can also see the notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.
- If you need help, please call Member Services or Medicare at the numbers listed above.

• **Section 7.2: Level 1 Appeal to change your hospital discharge date**

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

In Michigan, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. "An Important Message from Medicare about Your Rights" contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for a “fast review”.

Call before you leave the hospital and before your planned discharge date.

- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page 155.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. You can also call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. You can also get help from the MI Health Link Ombudsman by calling 1-888-746-6456.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a “fast review”

You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review” is “immediate review.”

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



The legal term for this written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at (855) 735-5604. 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. Or you can see a sample notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

• Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for another review.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

• Section 7.4: What happens if I miss an appeal deadline?
You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

NOTE: Your Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. This includes Alternate Appeals for inpatient mental health care. Contact your PIHP for more information. If you reside in Wayne County, including Detroit residents, you will contact the Detroit Wayne Integrated Health Network. Call 1-313-344-9099 (TTY: 1-800-630-1044). If you reside in the Macomb County, you will contact Macomb County Community Mental Health. Call 1-855-996-2264 (TTY: 711).

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary. It also means that 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.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say No to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
 - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 163 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.



Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
 - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
 - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

• **Section 8.1: We will tell you in advance when your coverage will be ending**

You will get a notice at least two calendar days before we stop paying for your care. This is called the Notice of Medicare Non-Coverage.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying for your care.

• **Section 8.2: Level 1 Appeal to continue your care**

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 on page 163 tells you how to file a complaint.)

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. Or call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

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.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 on page 160.

The legal term for the written notice is “**Notice of Medicare Non-Coverage**.” To get a sample copy, call Member Services at (855) 735-5604 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

What happens during the Quality Improvement Organization’s review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- Within one full day after reviewers have all the information they need, they will tell you their decision. You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is “**Detailed Explanation of Non-Coverage.**”

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

• Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.



In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says Yes?

- 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 must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

• Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.



Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that 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 review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a “fast review.”

We will give you our decision within 72 hours.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said No to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 163 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 9: Appeal options after Level 2 or External Appeals

• Section 9.1: Next steps for Medicare services and items

If you made a Level 1 or Internal Appeal and a Level 2 or External Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

• Section 9.2: Next steps for Michigan Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Michigan Medicaid.

If your appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision. If you disagree with the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MOAHR at 1-877-833-0870 for information about requirements you must meet to qualify for a rehearing/reconsideration.

If your appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision. If you disagree with the



decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 calendar days from the date of the decision.

If you need help at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

Section 10: How to make a complaint

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, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Molina Dual Options staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section 10.2 on page 165.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term for a “complaint” is a “**grievance**.”

The legal term for “making a complaint” is “**filing a grievance**.”

Are there different types of complaints?

Yes. 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 that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the MI Health Link Ombudsman at 1-888-746-6456.

NOTE: Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about internal complaints on behavioral health services. If you reside in Wayne County, including Detroit residents, you will contact the Detroit Wayne Integrated Health Network. Call 1-313-344-9099 (TTY: 1-800-630-1044). If you reside in the Macomb County, you will contact Macomb County Community Mental Health. Call

- **Section 10.1: Internal complaints**

To make an internal complaint, call Member Services at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. 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.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



- Complaints that are grievances must be resolved as expeditiously as your case requires, based on your health status, but no later than 30 calendar days after the date the Plan receives the oral or written grievance. Grievances filed orally, may be responded to orally unless you request a written response or the grievance concerns quality of care. Grievances filed in writing must be responded to in writing. Grievances may be filed orally by calling us at (855) 735-5604, TTY 711, Monday - Friday, 8 a.m. to 8 p.m., EST; or in writing by mailing to: Molina Dual Options, Attn: Appeals and Grievances, PO Box 22816, Long Beach, CA 90801.

The legal term for “fast complaint” is “expedited grievance.”

If possible, we will 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 need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, **we will tell you** and give you our reasons. We will respond whether we agree with the complaint or not.

• Section 10.2: External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell Michigan Medicaid about your complaint

You can also send your complaint to Michigan Medicaid. You can call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet based phone service.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



You can file a complaint with the 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 also visit [http://www.hhs.gov/ocr/for more information](http://www.hhs.gov/ocr/for%20more%20information).

You may also contact the local Office for Civil Rights at:

233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
Fax: 312-886-1807
TTY: 1-800-537-7697

You can also contact the Michigan Department of Civil Rights at:

110 W. Michigan Ave., Suite 800
Lansing, MI 48933
Phone: 517-335-3165
Fax: 517-241-0546
TTY: 517-241-1965

You may also have rights under the Americans with Disability Act and under state law. You can contact the MI Health Link Ombudsman for assistance. The phone number is 1-888-746-6456.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will 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, see Chapter 2.

In Michigan, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

You can tell the MI Health Link Ombudsman about your complaint

The MI Health Link Ombudsman also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we are required to provide. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan. The phone number is 1-888-746-6456. The services are free.

You can tell the State of Michigan about your complaint

If you have a problem with Molina Dual Options, you can contact the Michigan Department of Insurance and Financial Services (DIFS) at 1-877-999-6442, Monday through Friday from 8:00 AM to 5:00 PM. The call is free. You can also send an email to DIFS at: difs-HICAP@michigan.gov.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



For complaints about how your provider follows your wishes, contact:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
ATTN: Compliant Intake Section
611 W. Ottawa Street
PO Box 30670
Lansing, MI 48909-8170
Phone: 517-241-0205
E-mail: BPL-Complaints@Michigan.gov
FAX: 517-241-2389

To file a complaint against a licensed nurse, visit:

http://www.michigan.gov/lara/0,4601,7-154-72600_73836---,00.html

To file a complaint against all other licensed health professionals, visit:

http://www.michigan.gov/documents/lara/lara_ED_200PKT_AllegationPkt_477156_7.pdf



Chapter 10: Ending your membership in Molina Dual Options

Introduction

This chapter tells you when and how you can end your membership in our plan and what your health coverage options are after you leave our plan. If you leave our plan, you will still be in the Medicare and Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. When can you end your membership in our Medicare-Medicaid Plan

You can end your membership in Molina Dual Options Medicare Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

The change will be effective the first day of the next month after we get your request. If you leave our plan, you can get information about your:

- Medicare options, see the table on page 170
- Michigan Medicaid services, see page 171

You can get more information about when you can end your membership by calling:

- Michigan ENROLLS at 1-800-975-7630 Monday through Friday, 8 AM to 7 PM. TTY users should call 1-888-263-5897.
- The State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at 1-800-803-7174.
- 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.

NOTE: If you're in a drug management program, you may not be able to change plans. See Chapter 5 for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, tell Michigan Medicaid or Medicare that you want to leave Molina Dual Options:

- Call Michigan ENROLLS at 1-800-975-7630 Monday through Friday, 8 AM to 7 PM. TTY users should call 1-888-263-5897; 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 on page 170.

C. How to join a different Medicare-Medicaid Plan

If you want to keep getting your Medicare and Michigan Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call Michigan ENROLLS at 1-800-975-7630 Monday through Friday, 8 AM to 7 PM. TTY users should call 1-888-263-5897. Tell them you want to leave Molina Dual Options and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Your coverage with Molina Dual Options will end on the last day of the month that we get your request.

D. How to get Medicare and Michigan Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave Molina Dual Options, you will go back to getting your Medicare and Michigan Medicaid services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

Option	Change
<p>1. You can change to:</p> <p>A Medicare health plan (such as a Medicare Advantage Plan or Program of All-inclusive Care for the Elderly (PACE))</p>	<p>Here is what to do:</p> <p>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.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). <p>You will automatically be disenrolled from Molina Dual Options when your new plan's coverage begins.</p>
<p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do:</p> <p>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.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). <p>You will automatically be disenrolled from Molina Dual Options when your Original Medicare coverage begins.</p>

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Option	Change
<p>3. You can change to:</p> <p>Original Medicare without a separate Medicare prescription drug plan</p> <p>NOTE:</p> <p>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 don't want to join.</p> <p>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, call MMAP at 1-800-803-7174</p>	<p>Here is what to do:</p> <p>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.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). <p>You will automatically be disenrolled from Molina Dual Options when your Original Medicare coverage begins</p>

D2. How to get your Michigan Medicaid services

If you leave the Medicare-Medicaid Plan, you will get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long term supports and services and behavioral health care. If you leave the Medicare-Medicaid Plan, you can see any provider that accepts Michigan Medicaid.

E. Keep getting your medical services and drugs through our plan until your membership ends

If you leave Molina Dual Options, it may take time before your membership ends and your new Medicare and Michigan Medicaid coverage begins. See page 173 for more information. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



F. Other situations when your membership ends

These are the cases when Molina Dual Options must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Michigan Medicaid. Our plan is for people who qualify for both Medicare and Michigan Medicaid. If you lose Michigan Medicaid eligibility, you may have up to 90 days to regain eligibility. This period is considered the deeming period.
- 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, you need to call Member Services to find out if the place you are 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 will notify us if you aren't 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 Michigan Medicaid 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 Member ID Card to get medical care.
- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our plan for any health related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should 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.

You can also call the Beneficiary Help Line at 1-800-642-3195 (or 1-866-501-5656 for TTY users) Monday through Friday, 8 AM to 7 PM. You should also call the MI Health Link Ombudsman program. The phone number for the MI Health Link Ombudsman program is (888) 746-6456, Monday - Friday, 8:30 a.m. to 5 p.m., EST.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



H. 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 see Chapter 9 for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.



Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in Molina Dual Options. Key terms and their definitions appear in alphabetical order in the last chapter of the *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 this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Michigan Medicaid 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, or sex.

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 <http://www.hhs.gov/ocr> for more information.
- You can also call the Michigan Department of Civil Rights at 1-800-482-3604.
- Contact information for your Office of Civil Rights is:
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
Fax: 202-619-3818
TTY: 1-800-537-7697
- You may also contact the Michigan Department of Civil Rights at:
110 W. Michigan Ave., Suite 800
Lansing, MI 48933
Phone: 517-335-3165
Fax: 517-241-0546
TTY: 517-241-1965

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.

Discrimination is Against the Law

Molina Healthcare of Michigan (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin,

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

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

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

If you need these services, contact Molina Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (562) 499-0610.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can mail it to:

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

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

C. Notice about Medicare as a second payer and Medicaid as payer of last resort

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are 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 laws and regulations relating to the legal liability of third parties

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



for health care services to beneficiaries. We will take all reasonable measures to ensure that the Medicaid program is the payer of last resort.



Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *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: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

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.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services. We do not allow providers to "balance bill" you. Because Molina Dual Options pays the entire cost for your services, you should not get any bills from providers. Call Member Services if you get any bills that you do not understand.

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 made and sold by other drug companies.

Care Coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan for what supports and services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 explains how to contact CMS.

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 your care, network providers, or 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.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long term supports and services, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

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.

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, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three (3) tiers.

Durable medical equipment (DME): Certain items your doctor or other health care provider 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 is 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 function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is 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 drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

Freedom to Work: A program that provides health coverage to working people with disabilities in Michigan who are not otherwise eligible for Medicaid. People in the Freedom to Work program get full Medicaid coverage in exchange for a monthly premium. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is 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.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home health aide: A person who provides services that do not 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.
- Molina Dual Options must 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 the plan's cost sharing amount for services. Show your Molina Dual Options Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand. Because Molina Dual Options pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses 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 supports and services (LTSS): Long term supports and services are services that help improve a long term condition. LTSS includes nursing home services as well as home and community-based services. The home and community-based services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): See "Extra Help."

Medically necessary: This 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 must meet



accepted standards of medical practice. A specific service is determined medically (clinically) appropriate, necessary to meet needs, consistent with your diagnosis or health issue, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity includes those supports and services designed to assist you to attain or maintain a sufficient level of functioning to enable you to live in your community.

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 (see “Health plan”).

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers 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 that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid 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 (like lab tests, surgeries, and doctor visits) and supplies (like 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 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 Medicaid. Molina Dual Options includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid 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 explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Michigan Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term supports and services and medical costs. It covers extra services and 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 Michigan Medicaid. See Chapter 2 for information about how to contact Michigan Medicaid.

Model of care: The Model of Care is Molina Dual Options' plan for care coordination and medical services for all eligible members to deliver enrollee and family-centered healthcare. It encourages contact between enrollees, caregivers and their providers. Enrollees can request formal meetings with all their selected care providers together. The Model of Care was created to make sure that our members receive the right care, in the right setting at the right time.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are 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; behavioral health, substance use disorder, intellectual/developmental disability, and long term supports and services.

- 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 the health plan and accept our payment and not charge our 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 services 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 about the ombudsman in Chapters 2 and 9 of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can see 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 do not want to be in our plan, you can choose Original Medicare.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



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. Most drugs you get from out-of-network pharmacies are not covered by our plan 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 explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: See “Medicare Part A.”

Part B: See “Medicare Part B.”

Part C: See “Medicare Part C.”

Part D: See “Medicare Part D.”

Part D drugs: See “Medicare Part D drugs.”

Patient Pay Amount (PPA): The amount of money you may be asked to pay for the time you stay in a nursing home. This amount is based on your income and set by the state.

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. See Molina Dual Options’ Notice of Privacy Practices for more information about how Molina Dual Options protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Person-centered Planning Process: A process for planning and supporting a person getting services. The process builds on the individual’s desire to engage in activities that promote community life and that honor the individual’s preferences, choices, and abilities. The individual leads the person-centered planning process, and it involves families, friends, legal representatives, and professionals as the individual desires or requires.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems.

- He or she makes sure you get the care you need to stay healthy. He or she 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 see your primary care provider before you see any other health care provider.
- See Chapter 3 for information about getting care from primary care providers.

Prior authorization: An approval from Molina Dual Options you must get before you can get a specific service or drug or see an out-of-network provider. Molina Dual Options may not cover the service or drug if you don’t get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

- Covered services that need our plan's prior authorization are marked in the Benefits Chart in Chapter 4.

Some drugs are covered 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*.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items 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. They are paid by the federal government to check and improve the care given to patients. See Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can see someone that is not your PCP. If you don't get approval, Molina Dual Options may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4 to learn more about rehabilitation services.

Self-Determination: Self-determination is an option available to enrollees getting services through the MI Health Link HCBS home and community-based waiver program. It is a process that allows you to design and exercise control over your own life. This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget." If you choose to do so, you would also have control over the hiring and management of providers.

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 is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get Molina Dual Options.

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.

State Medicaid agency: The Michigan Department of Health and Human Services. This is the agency that runs Michigan's Medicaid program, helping people with limited incomes and resources pay for medical care and long term supports and services.

If you have questions, please call Molina Dual Options at (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free. **For more information**, visit www.MolinaHealthcare.com/Duals.



Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security 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.

Urgently needed 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 Dual Options Member Services

Method	Contact Information
CALL	(855) 735-5604 This call is free. Monday –Friday, 8 a.m. to 8 p.m., EST 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., EST
FAX	For Member Services: Fax: (248) 925-1767 For Part D (Rx) Services: Fax: (866) 290-1309
WRITE	For Medical Services/Medicaid Drugs: 880 West Long Lake Road, Suite 600 Troy, MI 48098 For Part D (Rx) Services: 7050 Union Park Center, Suite 200 Midvale, UT 84047
WEBSITE	www.MolinaHealthcare.com/Duals