2024
Summary of Benefits

Molina Dual Options MI-Health Link Medicare-Medicaid Plan

Michigan H7844-001

Serving the following counties: Wayne and Macomb

Effective January 1 through December 31, 2024

MOLINA® HEALTHCARE | MDHHS Michigan Department of Health & Human Services | MI Health Link

Molina Dual Options MI Health Link
Medicare - Medicaid Plan: **Summary of Benefits 2024**

Introduction

This document is a brief summary of the benefits and services covered by Molina Dual Options. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of 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. Disclaimers

This is a summary of health services covered by Molina Dual Options MI Health Link Medicare-Medicaid Plan for 2024. This is only a summary. Please read the *Member Handbook* for the full list of benefits.

- 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.
- Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, sexual orientation, mental or physical disability, health status, receipt of healthcare, medical or claims experience, medical history, genetic information, evidence of insurability, geographic location, or source of payment.
- Under Molina Dual Options you can get your Medicare and Michigan Medicaid services in one health plan. A Care Coordinator will help manage your health care needs.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Member Handbook.

- 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:ا كنت تتحدث اللغة العربية، نوفر لك خدمات المساعدة اللغوية المجانية. اتصل على735-5604 (855)، لمستخدمي أجهزة الهواتف النصية / أجهزة اتصالات المعاقين: 711، من الاثنين إلى الجمعة، من 8 صباحًا إلى 8 مساءً، بالتوقيت الشرقي. هذه المكالمة مجانية.
- You can also get this document for free in other formats, such as large print, braille, or audio. Call (855) 735-5604, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free.

- 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.
- The 2024 Member Handbook will be available by October 15. An up-to-date copy of the 2024 Member Handbook is always available on our website at www.MolinaHealthcare.com/Duals. You may also call Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST to ask us to mail you a 2024 Member Handbook.

B. Frequently Asked Questions

The following chart lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicare-Medicaid Plan?	A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Michigan Medicaid. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long term 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.
What is a Care Coordinator?	A Care Coordinator is a health professional who will help you get care and services that affect your health and wellbeing. You are assigned a Care Coordinator when you enroll with Molina Dual Options. Your Care Coordinator will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your Care Coordinator and set goals for healthy living. Whenever you have a question or a problem about your health or services or care you are getting from us, you can call your Care Coordinator. **Your Care Coordinator is your "go-to" person** for Molina Dual Options. Our goal in Molina Dual Options is to meet your needs in a way that works for you. This is why we call our program "person-centered." The person-centered planning process is when you work with your Care Coordinator to create a care plan that is about your goals, choices, and abilities. When you create your care plan, you are welcome to involve people you feel are key to your success, such as family members, friends, or legal representatives.
What are long term supports and services?	Long term supports and services are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital.
Will I get the same Medicare and Michigan Medicaid benefits in Molina Dual Options that I get now? (continued on the next page)	You will get your covered Medicare and Michigan Medicaid benefits directly from Molina Dual Options. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. If you are currently

Frequently Asked Questions (FAQ)	Answers
Will I get the same Medicare and Michigan Medicaid benefits in Molina Dual Options that I get now? (continued)	getting services for mental health, substance use, or intellectual/developmental disability needs, you will continue to get these services the same way you do now. When you enroll in Molina Dual Options, you and your care team will work together to develop an Individual Integrated Care and Supports Plan (IICSP) to address your health and support needs. You can keep using your doctors and getting your current services for up to 90 days, or 180 days depending on the service, while your IICSP is being completed. When you join our plan, if you are taking any Medicare Part D prescription drugs that Molina Dual Options does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for Molina Dual Options to cover your drug, if medically necessary.
Can I use the same doctors I use now?	Often that is the case. If your providers (including doctors, therapists, and pharmacies) work with Molina Dual Options and have a contract with us, you can keep using them. • Providers with an agreement with us are "in-network." **You must use the providers in Molina Dual Options' network.** • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of Molina Dual Option's plan. To find out if your doctors are in the plan's network, call Member Services or read Molina Dual Options' *Provider and Pharmacy Directory*, on the plan's website at www.MolinaHealthcare.com/Duals. If Molina Dual Options is new for you, you can continue using the doctors you use now while your IICSP is being developed.
What happens if I need a service but no one in Molina Dual Options' network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, Molina Dual Options will pay for the cost of an out-of-network provider.
Where is Molina Dual Options available?	The service area for this plan includes: Macomb and Wayne Counties, Michigan. You must live in one of these areas to join the plan.
Do I pay a monthly amount (also called a premium) under Molina Dual Options? (continued on the next page)	You will not pay any monthly premiums to Molina Dual Options for your health coverage. (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

Frequently Asked Questions (FAQ)	Answers
Do I pay a monthly amount (also called a premium) under Molina Dual Options? (continued)	& Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.
What is prior authorization (PA)?	Prior authorization means that you must get approval from Molina Dual Options before you can get a specific service or drug or use an out-of-network provider. Molina Dual Options may not cover the service or drug if you don't get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. Refer to Chapter 3 of the *Member Handbook* to learn more about prior authorization. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a prior authorization.
What is a referral?	A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. If you don't get approval, Molina Dual Options may not cover the services. You don't need a referral for certain specialists, such as women's health specialists. Refer to Chapter 3 of the *Member Handbook* to learn more about when you will need to get a referral from your PCP.
Do I pay a deductible?	No. You do not pay deductibles in Molina Dual Options MI-Health Link.
Do I have a coverage gap for drugs?	No. Because you have Medicaid you will not have a coverage gap stage for your drugs.

Frequently Asked Questions (FAQ)	Answers
Whom should I contact if I have questions or need help?	**If you have questions about behavioral health services and resources, please call the PIHP General Information Line. If you need immediate behavioral health services, please call the Behavioral Health Crisis Line in your county for the local Prepaid Inpatient Health Plan (PIHP).** **CALL** **PIHP General Information Line** For Wayne County residents, please contact Detroit Wayne Integrated Health Network at 1-313-344-9099. Monday - Friday, 8:00 a.m. to 4:30 p.m., EST 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. For Macomb County residents, please contact Macomb County Community Mental Health at 1-855-996-2264. Monday - Friday, 8:00 a.m. to 8:00 p.m., EST **Behavioral Health Crisis Lines** In the event of a mental health emergency in Wayne County, please call the 24 hour behavioral health crisis line at 1-855-927-4747. Calls to this number are free. We have free interpreter services for people who do not speak English. 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. Calls to this number are free. We have free interpreter services for people who do not speak English. **TTY** Please contact the listed TTY telephone numbers for: Detroit Wayne Integrated Health Network: 1-800-630-1044, or Macomb County Community Mental Health: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Calls to this number are free. Monday - Friday, 8:00 a.m. to 5:00 p.m., EST

Frequently Asked Questions (FAQ)	Answers
What is Balance Billing?	Balance Billing is when you receive a bill from your provider for services that should be covered. Balance billing is prohibited for covered services rendered to Medicaid and Medicare eligible members. Providers may not balance bill for services and supplies furnished to Qualified Medicare Beneficiaries; for them, Medicaid is responsible for deductibles, coinsurance and copayment amounts for Medicare Part A and B covered services.

C. Overview of Services

The following chart is a quick overview of what services you may need, your costs, and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor (This service is continued on the next page)	Visits to treat an injury or illness	$0	Prior authorization rules do not apply.
	Wellness visits, such as a physical	$0	Annual Wellness visit every 12 months. Prior authorization rules do not apply.
	Transportation to a doctor's office	$0	Prior authorization rules may apply if the trip is over 100 miles. You must call 2 business days in advance to make transportation arrangements. Urgent trips are available upon approval, if required. An urgent trip is a trip that is less than the 2 business day requirement and must meet an urgent transport exception. For more information on how to obtain approval for urgent trips, call Molina Dual Options Member Services at (855) 735-5604, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. Transportation Services to any health-related locations are covered.
	Specialist care	$0	Prior authorization rules do not apply.
	Care to keep you from getting sick, such as flu shots	$0	Prior authorization rules do not apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor (continued)	"Welcome to Medicare" preventive visit (one time only)	$0	Prior authorization rules do not apply.
You need medical tests	Lab tests, such as blood work	$0	Prior authorization rules may apply for select Outpatient Lab tests and services.
	X-rays or other pictures, such as CAT scans	$0	Prior authorization rules may apply. Outpatient X-ray services do not require prior authorization.
	Screening tests, such as tests to check for cancer	$0	Prior authorization rules may apply.
You need drugs to treat your illness or condition (This service is continued on the next page)	Generic drugs (no brand name)	$0 copay for a 31-day supply.	There may be limitations on the types of drugs covered. Please refer to Molina Dual Options' *List of Covered Drugs* (Drug List) for more information. A 90-day supply at retail and mail order pharmacy is available at no additional cost. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. There may be certain drugs that are limited to a 31-day supply. Some drugs have quantity limits. Your provider must get prior authorization from Molina Dual Options for certain drugs.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Brand name drugs	$0 copay for a 31-day supply.	There may be limitations on the types of drugs covered. Please refer to Molina Dual Options' *List of Covered Drugs* (Drug List) for more information. A 90-day supply is available at retail and mail order pharmacy at no additional cost. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. There may be certain drugs that are limited to a 31-day supply. Some drugs have quantity limits. Your provider must get prior authorization from Molina Dual Options for certain drugs.
	Non-Medicare Rx/Over-the-counter drugs	$0	There may be limitations on the types of drugs covered. Please refer to Molina Dual Options' *List of Covered Drugs* (Drug List) for more information.
	Over-the-counter (OTC) items	$0	We cover non-prescription Over-the-counter (OTC) items like vitamins, sunscreen, pain relievers, cough/ cold medicine, and bandages. You get $75 every 3 months that you can spend on plan-approved items. Your quarterly allowance becomes available to use in

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			January, April, July and October. Any dollar amount that you don't use will not carry over. You do not need a prescription from your doctor to get OTC items.
	Step therapy	$0	Step therapy may be required for certain drugs.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care	Emergency room services	$0	You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, without prior authorization. Emergency medical care is not covered outside the United States and its territories except under limited circumstances. Contact plan for details.
	Ambulance services	$0	Prior authorization is not required for emergency transportation. Prior Authorization rules may apply for non-emergency Ambulance services.
	Urgent care	$0	You may get urgent care services whenever you need it, anywhere in the United States or its territories, without prior authorization. Urgent medical care is not covered outside the United States and its territories except under limited circumstances. Contact plan for details.
You need hospital care	Hospital stay	$0	Our plan covers an unlimited number of days for an inpatient hospital stay if medically necessary. Prior authorization rules may apply.
	Doctor or surgeon care	$0	Prior authorization rules may apply.
You need help getting better or have special health needs	Rehabilitation services	$0	Prior authorization rules may apply.
	Medical equipment for home care	$0	Prior authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Skilled nursing care	$0	Prior authorization rules may apply.
You need eye care	Eye exams	$0	Exam to diagnose and treat diseases and conditions of the eye. Routine eye exam (1 exam every 2 years)
	Glasses	$0	Contact lenses (1 every year) Eyeglasses (frames and lenses) (1 every year) Eyeglass frames (1 every year) Eyeglass lenses (1 every year) Prior authorization is required for contact lenses only.
	Low Vision Aid	$0	The plan will pay for basic and essential low vision aids (such as magnifiers, readers, and certain other low vision aids).
You need dental care (This service is continued on the next page)	Dental check-ups, exams, x-rays, cleanings, fillings, tooth extractions, dentures and partial dentures and partial dentures, sealants, indirect restorations (crowns), root canal therapy/re-treatment of previous root canal, comprehensive periodontal evaluation, scaling in presence of inflammation, periodontal scaling and root planning, and other periodontal maintenance	$0	Molina Dual Options will pay for the following services: • Exams and evaluations are covered once every six months. • Cleaning is a covered benefit once every six months. • Silver diamine fluoride treatment is a covered benefit with a maximum of 6 applications per lifetime. • X-rays

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)			• 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. • Complete or partial dentures are covered once every five years. • Sealants are covered once every three years, if criteria are met • Indirect restorations (crowns) are covered once every 5 years per tooth, if criteria are met • Root canal therapy/re-treatment of previous root canal • Comprehensive periodontal evaluation • Scaling in presence of inflammation • Periodontal scaling and root planning • Other periodontal maintenance
You need hearing/auditory services	Hearing screenings	$0	Referral requirements may apply. Prior authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/auditory services (continued)	Hearing aid evaluation and fitting	$0	Hearing aid fitting/evaluation are offered 2 every year. Referral requirements may apply. Prior authorization rules may apply.
	Hearing aids	$0	Hearing exams and supplies (including hearing aids, maintenance and repair of hearing aids) will be covered for all ages. Hearing aids are covered once every 5 years. 36 batteries per hearing aid are distributed every 6 months. Referral requirements may apply. Prior authorization rules may apply.
You have a chronic condition, such as diabetes or heart disease	Services to help manage your disease	$0	Coverage includes self-management training and disease management program for diabetics. Prior authorization rules do not apply.
	Diabetes supplies and services	$0	Benefit includes diabetic monitoring supplies and therapeutic shoes or inserts. Prior authorization rules may apply.
You have a mental health condition	Behavioral health services	$0	Provided through the Prepaid Inpatient Health Plan (PIHP)

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)			The Prepaid Inpatient Health Plan must approve admission for a psychiatric inpatient hospital stay. Our plan covers an unlimited number of days for an inpatient hospital stay if medically necessary. Prior authorization rules may apply.
You have concerns related to substance use	Substance use services	$0	Provided through the Prepaid Inpatient Health Plan (PIHP) The Prepaid Inpatient Health Plan must approve admission for Outpatient Substance Abuse Services. Outpatient group therapy visit. Outpatient individual therapy visit. Prior authorization rules may apply.
	Opioid Treatment Program	$0	Prior authorization rules may apply.
You need durable medical equipment (DME)	Wheelchairs	$0	Prior authorization rules may apply.
	Nebulizers	$0	Prior authorization rules may apply.
	Crutches	$0	Prior authorization rules may apply.
	Walkers	$0	Prior authorization rules may apply.
	Oxygen equipment and supplies	$0	Prior authorization rules may apply.
You need help living at home (This service is continued on the next page)	Meals brought to your home	$0	Limited to 2 meals a day. Prior authorization rules may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	Chore services, such as heavy household chores and mowing and raking	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Prior authorization rules may apply.
	Preventive nursing services	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Limited to no more than two hours per visit.
	Private duty nursing services to provide skilled nursing services in your home	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Referral requirements may apply. 16 hours every day. Prior authorization rules may apply.
	Fiscal intermediary services to help you control your budget and choose the staff to work with you	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Prior authorization rules may apply.
	Environmental modifications to your home, such as adding ramps and widening doorways	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Prior authorization rules may apply.
	Expanded community living supports to help you complete activities of daily living and instrumental activities of daily living	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Prior authorization rules may apply.
	Personal care services	$0	Prior authorization rule may apply.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	(You may be able to choose your own personal care assistant. Call Member Services for more information.)		
	Personal Emergency Response System (PERS)	$0	Prior authorization rules may apply.
	Assistive technology	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Prior authorization rules may apply.
	Home health care services	$0	Prior authorization rules may apply.
	Adult day services or other support services	$0	Services are only available to individuals on the MI Health Link 1915(c) waiver. Prior authorization rules may apply. Services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, based on your needs.
You need a place to live with people available to help you	Nursing home care	A Patient Pay Amount (PPA) may be required.	Services are only available to individuals who meet the Michigan Medicaid Nursing Facility Level of Care Determination standards. Prior authorization rules may apply.
Your caregiver needs some time off (This service is continued on the next page)	Respite care	$0	General Services: Up to 14 days every year. All members are eligible for respite services if criteria is met.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Your caregiver needs some time off (continued)			Respite care is also available to hospice members. Prior authorization rules may apply.
Additional covered services (This service is continued on the next page)	Additional sessions of Smoking and Tobacco Cessation Counseling	$0	
	COVID-19 Home Test Kit	$0	Up to 8 over-the-counter Covid-19 home test kits per calendar month.
	Doula Services	$0	Coverage includes prenatal and postpartum visits, 6 visits per pregnancy and attendance at labor and delivery, 1 visit per pregnancy. Doula services must be recommended by a licensed healthcare provider. Additional visits may be approved through the prior authorization process.
	Fitness Benefit	$0	The Silver&Fit program offers you access to participating fitness centers and the Home Fitness program. Visit SilverandFit.com to find a fitness center and/or to enroll in the Home Fitness program. If you choose to workout at a participating fitness center and you have a caregiver, you can bring them with you to help you use the fitness center's services and equipment.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional covered services (continued)			If you choose to also work out at home, you can pick one Home Fitness Kit from ten different options, including a fitness activity tracker.
	Health Education	$0	
	Home Infusion Therapy	$0	The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home.
	Podiatry Services	$0	Routine foot care (for up to 6 visit(s) every year). Prior authorization rules may apply.

D. Services covered outside of Molina Dual Options

This is not a complete list. Call your Care Coordinator or Member Services to find out about other services not covered by Molina Dual Options but available through Medicare or Michigan Medicaid.

Other services covered by Medicare or Michigan Medicaid	Your costs
Prepaid Inpatient Health Plan (PIHP) services: Inpatient behavioral health care, outpatient substance use disorder services, and partial hospitalization services	$0
Some hospice care services	$0
Medicare-covered acupuncture for chronic lower back pain	$0 Prior Authorization may be required.
Telehealth	$0

E. Services that Molina Dual Options, Medicare, and Michigan Medicaid do not cover

This is not a complete list. Call your Care Coordinator or Member Services to find out about other excluded services.

Services not covered by Molina Dual Options, Medicare, or Michigan Medicaid	
Alternative Therapies	
Cosmetic surgery or cosmetic work	
Worldwide Emergency Coverage	
Infertility services and Elective abortions	
Reversal of sterilization	
Experimental/investigational drugs	
Biological agents, procedures, devices or equipment	

F. Your rights as a member of the plan

As a member of Molina Dual Options, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
  - Get information in other formats (e.g., large print, braille, audio)
  - Be free from any form of physical restraint or seclusion
  - Not be billed by providers
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a format you can understand. These rights include getting information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and care managers

- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a Primary Care Provider (PCP) and change your PCP at any time during the year
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered
  - Refuse treatment, even if your doctor advises against it
  - Stop taking medicine
  - Ask for a second opinion. Molina Dual Options will pay for the cost of your second opinion visit.
- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your doctors and your health plan
- **You have the right to seek emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior authorization in an emergency
  - Use an out of network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected.
  - Have your personal health information kept private.
- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - File a complaint or grievance against us or our providers

- Ask for a state fair hearing
- Get a detailed reason for why services were denied

For more information about your rights, you can read the Molina Dual Options *Member Handbook*. If you have questions, you can also call Molina Dual Options Member Services.

G. How to file a complaint or appeal a denied service

If you have a complaint or think Molina Dual Options should cover something we denied, call Molina Dual Options at the number at the bottom of the page. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the Molina Dual Options *Member Handbook*. You can also call Molina Dual Options Member Services.

Molina Dual Options
Attn: Grievances and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977
Fax: (562) 499-0610

H. What do you do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at Molina Dual Options Member Services. Phone numbers are on the cover of this summary.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, contact the Michigan Attorney General's Health Care Fraud Division Hotline by phone at (800) 24-ABUSE (800-242-2873), by e-mail at hcf@michigan.gov or use the on-line Michigan Medicaid Fraud Complaint Form found at secure.ag.state.mi.us/complaints/medicaid.aspx.


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MDHHS
Michigan Department of Health & Human Services
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