Molina Medicare Complete Care Plus (HMO D-SNP) *Member Handbook*

01/01/2026 – 12/31/2026

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

Member Handbook Introduction

This *Member Handbook,* otherwise known as the *Evidence of Coverage,* tells you about your coverage under our plan through 12/31/2026. It explains health care services, behavioral health drug coverage, and long-term services and supports (LTSS). LTSS help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook*.

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

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

This document is available for free in Spanish.

- You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free. To request your preferred language other than English and/or alternate format, call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.
- We will maintain a record of our member’s preferred language and/or format preferences, and we will keep this information as a standing request for future mailings and communications. This will ensure that our members will not have to make a separate request each time, **and**
- To change a standing request, call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.

- Molina Medicare Complete Care Plus (HMO D-SNP) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.
- Molina Healthcare is a D-SNP plan with a Medicare contract. D-SNP plans have a contract with the state Medicaid program. Enrollment depends on contract renewal.
- Coverage under Molina Medicare Complete Care Plus (HMO D-SNP) is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.
- Benefits and/or copayments may change on January 1, 2027.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.

Table of Contents

Chapter 1: Getting started as a member ……..…… 4

Chapter 2: Important phone numbers and resources ……..……..……...…14

Chapter 3: Using our plan's coverage for your health care and other covered services ……..……32

Chapter 4: Benefits chart ……..……..……..48

Chapter 5: Getting your outpatient drugs …….....127

Chapter 6: What you pay for your Medicare and STAR+PLUS drugs…..…….148

Chapter 7: Asking us to pay a bill you got for covered services or drugs…...…166

Chapter 8: Your rights and responsibilities……172

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)……197

Chapter 10: Ending your membership in our plan……..…241

Chapter 11: Legal Notices……..……251

Chapter 12: Definitions of important words……253

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Molina Medicare Complete Care Plus (HMO D-SNP), a health plan that covers all of your Medicare and STAR+PLUS services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

A. Welcome to our plan

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

B. Information about Medicare and STAR+PLUS

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. STAR+PLUS

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

Each state decides:

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

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

Medicare and the state of Texas approved our plan. You can get Medicare and STAR+PLUS services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Texas allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and STAR+PLUS services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and STAR+PLUS services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and STAR+PLUS benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a service coordination team that you help put together. Your service coordination team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a service coordinator. This is a person who works with you, with our plan, and with your service coordination team to help make a care plan.
- You're able to direct your own care with help from your service coordination team and service coordinator.
- Your service coordination team and service coordinator work with you to make a care plan designed to meet **your** health needs. The service coordination team helps coordinate the services you need. For example, this means that your service coordination team makes sure:

» Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.

» Your test results are shared with all your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in Texas: Hidalgo.

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

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for STAR+PLUS **and** at least one of the following:
  - have a physical disability or a mental disability and qualify for Supplemental Security Income (SSI), **or**
  - qualify for STAR+PLUS because you receive Home and Community-based Services (HBCS) waiver services; **and**
- you're NOT enrolled in one of the following 1915(c) waiver programs:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HCBS)
    - Texas Home Living Program (TxHmL)

If you lose eligibility but can be expected to regain it within 6 months (180 days) then you're still eligible for our plan.

Call Member Services for more information.

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

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

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

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

We'll send you more information about this HRA.

G. Your service coordination team and service plan

G1. Service coordination team

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

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

G2. Service plan

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

Your service plan includes:

- Services you will receive or are approved to receive, including any long-term services and supports (LTSS) and/or STAR+PLUS HCBS waiver services you may receive
- Providers who will deliver our services
- your health care goals, **and**
- a timeline for getting the services you need.

Your service coordination team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your service plan is created based on your needs and goals. Your service coordination team works with you to update your service plan at least every year.

H. Summary of important costs

Our plan has no premium.

I. This Member Handbook

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

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website.

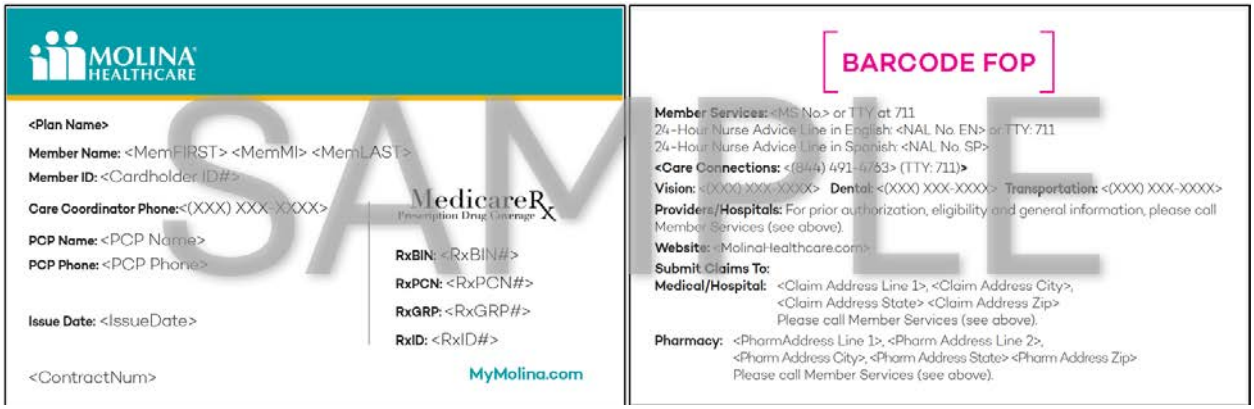
The contract is in effect for the months you're enrolled in our plan between 01/01/2026 and 12/31/2026.

J. Other important information you get from us

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

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and STAR+PLUS services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



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

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your STAR+PLUS card to get most services. Keep those cards in a safe place

in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out 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 our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at MolinaHealthcare.com/Medicare or download it from this website.

The Provider and Pharmacy Directory includes information such as:

- How to get the most up-to-date information about network providers in your area
- What are network providers, primary care providers and specialists including (Indian Health Providers)?
- How to reach your service coordinator
- How to choose a Primary Care Physician (PCP)
- Getting Long Term Services and Supports (LTSS)
- Identifying Providers in our network
- How to find providers in your area
- List of Network Providers, including:
    - Health care professionals (PCP, Network Specialists, etc.)
    - Facilities (Hospitals, Surgery Centers, etc.)
    - Support providers (Home Health, DME, etc.)
- Pharmacies in our network including:
    - Retail pharmacies
    - Mail order

- Home infusion pharmacies
- Long term care pharmacies

Definition of network providers

- Our network providers include:
  - » doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - » clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - » LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or STAR+PLUS.
- Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

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

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

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they have been removed and replaced as described in **Chapter 5, Section E.** Medicare approved the Molina Medicare Complete Care Plus (HMO D-SNP) *Drug List.*

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

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

J4. *The Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take. **Chapter 6** of this *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

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

K. Keeping your membership record up to date

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

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

You can also make some updates to your information online by logging into www.MyMolina.com.

K1. Privacy of personal health information (PHI)

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

Chapter 2: Important phone numbers and resources

Introduction

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

Member Services

CALL	(866) 856-8699 This call is free. Monday – Friday, 8 a.m. to 8 p.m. local time Assistive technologies, including self-service and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays. **In Case of An Emergency:** Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP) or you may also contact our 24-Hour Nurse Advice Line at (888) 275-8750. We have free interpreter services for people who don't speak English.
TTY	711 This call is free. Monday – Friday, 8 a.m. to 8 p.m. local time
FAX	*For Member Services:* *(844) 834-2155* *For Part D (Rx) Services:* *Fax: (866) 290-1309*

WRITE	For Member Services: Molina Medicare Complete Care Plus (HMO D-SNP) 2200 Highway 121, Suite 270A Bedford, TX 76021 For Medicaid Drugs (items marked with an (*) are Non-Part D Drugs or OTC items that are covered by Medicaid): Molina Healthcare of Texas Attn: Member Complaints & Appeals 182273 Chattanooga, TN 37422 For Part D (Rx) Services: Molina Medicare Complete Care Plus (HMO D-SNP) 7050 Union Park Center, Suite 200 Midvale, UT 84047
WEBSITE	*MolinaHealthcare.com/Medicare*

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.

  - To learn more about coverage decisions, refer to Chapter 9 of this *Member Handbook*.

- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to Chapter 9 of this *Member Handbook* or contact Member Services.

- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to Section F
    - » You can call us and explain your complaint at phone number.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
    - » You can complain about your STAR+PLUS plan to the Texas Health and Human Services (HHS) Office of the Ombudsman at 877-787-8999 or by faxing 888-780-8099 or writing to:

      HHS Office of the Ombudsman
      PO Box 13247
      Austin, Texas 78711-3247
  - To learn more about making a complaint about your healthcare, refer to Chapter 9 of this *Member Handbook*.

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - – your benefits and covered drugs **or**

  - the amount we pay for your drugs.
  - » This applies to your Medicare Part D drugs.
  - o STAR+PLUS will pay for wrap-around drugs/products for dual-eligible members after commercial insurance has been billed or if there's no commercial insurance on file. These drugs include nonprescription (over-the-counter) medications, some products used in symptomatic relief of cough and colds, and some prescription vitamins and mineral products.
  - o For more on coverage decisions about your drugs, refer to Chapter 9 of this *Member Handbook*.

- appeals about your drugs
  - o An appeal is a way to ask us to change a coverage decision.
  - o For more on making an appeal about your drugs, refer to Chapter 9 of this *Member Handbook*.

- complaints about your drugs
  - o You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - o If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)
  - o You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - o For more on making a complaint about your drugs, refer to Chapter 9 of this *Member Handbook*.

- payment for health care or drugs you already paid for
  - o For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7 of this *Member Handbook*.
  - o If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9 of this *Member Handbook*.

Your Service Coordinator

Your Service Coordinator is your main contact. Service Coordination helps you manage all of your providers, services and will make sure you get what you need. You and/or your legally authorized representative may request a change in the Service Coordinator assigned to you by calling the Service Coordination line. We may make changes to the Service Coordinator assignment based upon your needs (cultural / linguistic / physical / behavioral health) or location. If you have questions, call your Service Coordinator for more information.

CALL	(866) 409-0039 This call is free. Monday - Friday, 8 a.m. to 6 p.m., CST. Assistive technologies, including self-service and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sunday. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. Monday – Friday, 8 a.m. to 6 p.m., CST
WRITE	Molina Medicare Complete Care Plus (HMO D-SNP) 2200 Highway 121, STE 270A Bedford, TX 76021
WEBSITE	MolinaHealthcare.com/Medicare

Contact your service coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about long-term services and supports
- questions about accessing community supports
- skilled nursing care

- physical therapy
- occupational therapy
- speech therapy
- medical social services
- home health care
- Personal Assistance Services (PAS)
- Day Activity and Health Services (DAHS)
- protective supervision
- therapy – physical therapy, occupational therapy, speech therapy
- in home or out of home respite services
- in home nursing services
- Emergency Response Services (ERS)
- home delivered meals
- minor home modifications
- adaptive aids
- medical supplies
- dental services
- adult foster care

Health Information, Counseling, and Advocacy Program (HICAP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Texas, the SHIP is called Health Information, Counseling, and Advocacy Program (HICAP).

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Contact Type	
CALL	800-252-9240 Monday-Friday 8:00 a.m. to 5:00 p.m. CST
TTY	711 or (800) 735-2989 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin, TX 78751
WEBSITE	hhs.texas.gov/services/health/medicare

Contact HICAP for help with:

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

Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO)

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

CALL	888-315-0636
TTY	*711*
WRITE	5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609
WEBSITE	www.acentraqio.com

Contact Acentra for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - 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.

Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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. This agency contracts with Medicare Advantage organizations, including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly “wellness” visits). • Get Medicare appeals information and forms. Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

STAR+PLUS

STAR+PLUS is a Texas Medicaid-managed care program for adults who have disabilities or are age 65 or older and provides healthcare and long-term services and supports through our health plan.

You're enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Texas Medicaid. Be sure to mention you're enrolled in a STAR+PLUS plan.

CALL	1-800-252-8263 or 2-1-1
TTY	1-800-735-2989 or 7-1-1
WRITE	Texas Health and Human Services P.O. Box 149024 Austin, Texas 78714-9024
WEBSITE	www.yourtexasbenefits.com/Learn/Home

HHS Office of the Ombudsman

The HHS Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. HHS Office of the Ombudsman also helps you with service or billing problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	877-787-8999 Monday-Friday, 8:00 a.m. to 5:00 p.m. CST
TTY	1-800-735-2989 *This number is for people who have* difficulty with *hearing or speaking. You must have special telephone equipment to call it*.
WRITE	Texas Health and Human Services Office of the Ombudsman P.O. Box 13247 Austin, TX 78711-3247
WEBSITE	www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman

Texas Office of the Long-Term Care Ombudsman

The Texas Office of the Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Texas Office of the Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

CALL	800-252-2412 Monday-Friday, 8:00 a.m. to 5:00 p.m. CST
WRITE	HHS Office of the Ombudsman P.O. Box 13247 Austin, Texas 78711-3247
EMAIL	ltc.ombudsman@hhs.texas.gov
WEBSITE	www.apps.hhs.texas.gov/news_info/ombudsman/

Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- The Best Available Evidence (BAE) located on the web at https://www.cms.gov/medicare/enrollment-renewal/part-d-prescribers/best-available-evidence-bae. BAE is used to determine a member's Low Income Subsidy. Our Member Services department and Pharmacy department identify cases where the BAE policy applies. Members may send BAE documentation to establish eligibility to the Member Services address listed in Chapter 2. Additionally, you may contact Member Services if you have questions. Acceptable forms of evidence are:
- SSA Award Letter
- Notice of Award
- Supplemental Security Income

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

I2. State Pharmaceutical Assistance Program (SPAP)

If you're enrolled in a SPAP, or any other program that provides coverage for Medicare Part D drugs other than "Extra Help" you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

I3. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Texas HIV Medication Program.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call Texas HIV Medication Program at 800-255-1090.

I4. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit www.Medicare.gov.

Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, it's important that you contact Social Security to let them know.

CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	www.rrb.gov

Other resources

Enrollment Broker: STAR+PLUS Help Line (877) 782-6440, Monday - Friday, 8 a.m. to 6 p.m., CST

Medicaid Managed Care 1-866-566-8989;

Medicaid Managed Care TTY# 7-1-1 or 1-800-735-2989 (Relay Texas)

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your service 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 if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

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

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and STAR+PLUS. This includes behavioral health and LTSS.

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

- The care you get must be included in our Medical Benefits Chart in Chapter 4 of this *Member Handbook*.
- The care must be **medically necessary.** By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care** *provider* **(PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
    - In most cases, *your network PCP* must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter)**.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
    - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to Section I in this chapter).
    - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. *Molina Medicare Complete Care Plus (HMO D-SNP) requires a prior authorization. We need to make a decision that the care is medically necessary before you get care from an out of network provider.* In this situation, we cover the care as if yo*u*

got it from a network provider. For information about getting approval to use an out-of-network provider, go to Section **D4** in this chapter.

- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

Your service coordinator

C1. What a service coordinator is

Your Service Coordinator is your main contact person and helps manage all your providers and services to make sure you get the care you need.

C2. How you can contact your service coordinator

You can contact the Service Coordination line at (866) 409-0039, TTY: 711, Monday - Friday, 8 a.m. to 6 p.m., CST. This call is free.

C3. How you can change your service coordinator

You and/or your legal authorized representative may request a change in the Service Coordinator assigned to you, as needed by calling the Service Coordination line. *Molina Medicare Complete Care Plus (HMO D-SNP)* HealthCare Services staff may make changes to member Service Coordinator assignments based on member needs (cultural/linguistic/physical/ behavioral health) or location.

C4. What a Service Coordinator can do for you

Your Service Coordinator can help determine your health care, long-term services and supports and behavioral health care needs and help write a service plan with you and your doctor. Your Service Coordinator can also talk with any case managers, providers, pharmacists or other persons that you say are important for your health care needs and help you find the services you need to stay healthy.

Care from providers

D1. Care from a primary care provider (PCP)

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

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

A Primary Care Provider (PCP) is a physician, nurse practitioner, or health care professional and/or medical home or clinic (Federally Qualified Health Centers–FQHC) who gives you routine health care. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care
- "Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.
- In some special cases, a specialist can serve as a PCP. The member/provider will need to call Member Services to make this request. *Molina Medicare Complete Care Plus (HMO D-SNP)* will review for medical necessity/appropriateness and will obtain the written agreement from the specialist that he or she is willing to accept responsibility for coordination of all of the member's health care needs. If the specialist is not willing to serve as the PCP, the request cannot be approved.

Molina Medicare Complete Care Plus (HMO D-SNP) maintains a network of specialty providers to care for its members. Prior authorization may be required in some cases for you to receive specialty services.

Your choice of PCP

Your relationship with your PCP is important. When you pick your PCP, try to choose one close to your home. This will make it easier to get to your visits and get the care you need when you need it. A full list of available PCPs can be accessed online at https://molina.sapphirethreesixtyfive.com/.

For a printed copy of the most current Provider/Pharmacy Directory, or to seek additional assistance in choosing a PCP, please contact Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.

Once you have chosen your PCP, we recommend that you have all your medical records transferred to his or her office. This will provide your PCP access to your medical history and make him or her aware of any existing health care conditions you may have. Your PCP is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. The name and office telephone number of your PCP is printed on your membership card.

Option to change your PCP

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

You can call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time if you want more information about our *Molina Medicare Complete Care Plus (HMO D-SNP)* providers or if you need help changing your PCP. Member Services will make the PCP change effective on the first day of the following month. For some providers, you may need a referral from your PCP (except for emergency and out of area urgent care services).

D2. Care from specialists and other network providers

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

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

We have many specialty providers to care for our members. If there is a specialist that you want to use, ask your PCP. Although you do not need a referral to see a network provider, your PCP can still refer you to or recommend other network providers. For some services, you may need prior authorization from us. You, your Service Coordinator or your provider can request prior authorization by phone, fax or mail.

Please see the Benefits Chart in Chapter 4 for information about which services require prior authorization.

D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.

- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- *If we* can't *find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.* In most cases prior authorization is needed
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (*Refer to Chapter 9 for* more *information*.)

D4. Out-of-network providers

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

- We can't pay a provider who isn't eligible to participate in Medicare and/or STAR+PLUS.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

Long-term services and supports (LTSS)

Behavioral *health (mental health and substance use disorder) services*

Molina Medicare Complete Care Plus (HMO D-SNP) provides access to many behavioral health providers. A list of providers can be located on the Molina Medicare Complete Care Plus (HMO D-SNP) member website or by calling Member Services. For a copy of the most current Provider/Pharmacy Directory, or to seek additional assistance in choosing a behavioral health provider, please contact Member Services. For some services you may be required to get a prior authorization. Your behavioral health provider will obtain necessary authorizations. You are able to self-refer for behavioral health services, and do not require a referral from your PCP. For more information on behavioral health, please contact Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.

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

How to get self-directed care

E1. Consumer Directed Services (CDS) allows people to hire and manage people who provide their services.

Consumer Directed Services are available for both non-waiver and waiver members interested in Consumer-Directed Services (CDS). You can work with your Service Coordinator to determine a plan. Not all services are eligible for CDS. In the Consumer-Directed Option Model, you or your Legally Authorized Representative (LAR) are the employer and have control over the hiring, management, and termination of an individual providing Personal Assistant Services (PAS), in-home or out-of-home respite, nursing, Physical Therapy (PT), Occupational Therapy (OT), and/or Speech and Language Therapy (SLT). You will need to choose a Financial Management Service Agency (FMSA) to help you with the employer-related administrative functions such as payroll, substitute (back-up), and filing tax-related reports. Your Service Coordinator can answer questions about CDS or help you coordinate services.

E2. Who can get self-directed care (for example, if it's limited to waiver populations)

You can visit the CDS website at www.hhs.texas.gov/providers/long-term-care-providers/consumer-directed-services-cds. Here, you can read more about the CDS

option. You can also see a list of consumer directed services agencies, and contact them to find out more about the CDS option and how it works.

Non-Emergency Medical Transportation (NEMT) services

F1. What NEMT Services are

NEMT Services provide transportation to nonemergency health care appointments if you have no other transportation options.

- *These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get health care services.*
    - *These* trips **don't** *include ambulance trips.*

F2. What services are included

NEMT Services include:

- *Passes or tickets for transportation, such as mass transit within and between cities or states (including by rail or bus).*
- *Commercial airline transportation services.*
- *Demand response (curb-to-curb) transportation services in private buses, vans, or sedans (including wheelchair-accessible vehicles, if necessary).*
- *Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.*
- *Transportation costs for your NEMT attendant if you need them to travel to your appointment with you. An NEMT attendant is:*
    - *An adult providing necessary mobility or personal or language assistance to you during transportation. (For example, this can include an adult serving as your personal attendant.)*
    - *A service animal providing necessary mobility or personal assistance to you during transportation and that occupies a seat that would otherwise be filled by another person.*
    - *An adult traveling with you because a health care provider has stated in writing that you require an attendant.*

- *Transportation for members in a nursing facility is only covered when the member is traveling to and from a dialysis appointment or if the member is being discharged from a nursing facility to a lower level of care or home setting.*

F3. How to schedule NEMT Services

To schedule a ride, members should contact Access2Care at (866) 462-4856 TTY: 711 24 hours a day, 7 days a week. Remember to schedule rides as early as possible, and **at least two business days before you need the ride**. You may schedule rides with less notice in certain cases, including:

- Pickup after a hospital discharge.
- Trips to the pharmacy for medication or approved medical supplies.
- Trips for urgent conditions. (An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.)

Schedule rides for long-distance trips at least five days in advance.

If you have a scheduled ride and your health care appointment is cancelled **before** the trip, contact Access2Care at (866) 462-4856 TTY: 711 24 hours a day, 7 days a week right away.

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

G1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. 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 life and if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- In the case of a pregnant woman in active labor, when:
    - There isn't enough time to safely transfer you to another hospital before delivery.

- A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, tell our plan** about your emergency**.** We follow up on your emergency care. You or your service coordinator should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. To get more information call the phone number on the back of your ID Card).

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Definition of post-stabilization

Post-stabilization care services are services that keep your condition stable following emergency medical care.

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

If you have a behavioral health emergency, go to the nearest emergency room or call 911. We also have a Behavioral Health Crisis Hotline if you need to talk to a nurse immediately. That phone number is (800) 818-5837.

Getting emergency care if it wasn't an emergency

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

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

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

G2. Urgently needed care

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

Urgently needed care in *our* plan's service area

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

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

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

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

Urgently needed care outside *our* plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

G3. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: MolinaHealthcare.com/Medicare.

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

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.

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

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

H1. What to do if our plan doesn't cover services

Our plan covers all services:

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

If you get services that our plan doesn't cover, **you pay the full cost yourself.**

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

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

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

Coverage of health care services in a clinical research study

I1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care *provider*. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

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

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your service coordinator to contact Member Services to let us know you'll take part in a clinical trial.

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

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

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

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

I3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-

studies.pdf).You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

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

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

- "Non-excepted" medical treatment is any care or treatment that's voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's 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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

Durable medical equipment (DME)

K1. DME as a member of our plan

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

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you *usually* **won't** own the rented DME items, no matter how long you rent it.

In some *limited situations, we transfer ownership of the DME item to you. Call Member Services* at the phone number at the bottom of the page for more information.

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

K2. DME ownership if you switch to Original Medicare

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

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

- you didn't 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 or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

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

K3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

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

K4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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

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

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

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

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

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

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

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in Chapter 5 of this *Member Handbook*. *This chapter also explains limits on some services*.

Because you get help *from* STAR+PLUS*, you pay nothing for your covered services as long as you follow* our *plan's rules. Refer to Chapter 3* of this *Member Handbook for details about* our *plan's rules.*

If you need help understanding what services are covered, call your service coordinator *and/or Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time*.

B. Rules against providers charging you for services

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

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

C. About our plan's Benefits Chart

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

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

- We provide covered *Medicare* STAR+PLUS *covered services according to the rules set by Medicare and* STAR+PLUS*.*
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- *For new enrollees,* for *the* first *90* days we *may not require* you to get approval in advance *for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.*
- *You get your care from a network provider. A network provider is a provider who works with* us. *In most cases, care you get from an out-of-network provider* won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. *Chapter 3* of this *Member Handbook has more information about using network and out-of-network providers*.
- *You have a primary care provider (PCP) or a* care *team providing and managing your care. In most cases, your PCP must give you approval before you can use* a provider *that* isn't *your PCP or use other providers in* our *plan's network. This is called a referral. Chapter 3* of this *Member Handbook has more information about getting a referral and when you* **don't** *need* one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered *services in the Benefits Chart* that need PA with an asterisk (*).
- *If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.*

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits:
  - Autoimmune disorders
  - Cancer
  - Cardiovascular disorders
  - Chronic alcohol use disorder and other substance use disorders (SUDs)
  - Chronic and disabling mental health conditions
  - Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
  - Chronic gastrointestinal disease

- Chronic heart failure
- Chronic kidney disease
- Chronic lung disorders
- Conditions associated with cognitive impairment
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Immunodeficiency and Immunosuppressive disorders
- Neurologic disorders
- Overweight, obesity, and metabolic syndrome,
- Post-organ transplantation
- Severe hematologic disorders
- Stroke

- Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.
- Contact us for additional information.

All preventive services are free. This apple 🍎 shows the preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

Covered Service		What you pay
🍎	**Abdominal aortic aneurysm screening** We pay for a one-time ultrasound screening for people at risk. Our 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

	Acupuncture* We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	$0

Covered Service		What you pay
	The plan also covers 20 visits/year for other conditions as Medicare Supplemental benefit.	
🍎	**Alcohol misuse screening and counseling** We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care *provider* (PCP) or practitioner in a primary care setting.	$0
	Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0

Covered Service		What you pay
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare visit. However, you don't need to have had a Welcome to Medicare visit to get annual wellness visits after you've had Part B for 12 months.	$0
	Behavioral health services* The plan will pay for the following services: • mental health targeted case management • mental health rehabilitative services o outpatient mental health care We pay for behavioral health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • **any o**ther Medicare-qualified mental health care professional as allowed under applicable state laws	$0

Covered Service		What you pay
	Birth Centers The plan covers free-standing birth center services in a licensed free-standing birth center. Call Member Services at (866) 856-8699, TTY: 711, Monday – Friday 8 a.m. to 8 p.m., local time to see if there are any qualified centers in your area.	$0
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women aged 40 and older • clinical breast exams once every 24 months	$0
	Cardiac (heart) rehabilitation services* We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's *order*. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0

Covered Service		What you pay
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care *provider* (PCP) to help lower your risk for heart disease. During the visit your doctor may: • discuss aspirin use, • check your blood pressure, and/or • give you tips to make sure you're eating well.	$0
	Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0
	Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	$0

Covered Service		What you pay
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment •	*$0*
	Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	*$0* Cost sharing for this service will vary depending on individual services provided under the course of treatment.

Covered Service		What you pay
	Colorectal cancer screening We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Colorectal cancer screening (continued) • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after aMedicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy orscreening colonoscopy that involves the removal of tissue or other matter, or otherprocedure furnished in connection with, as a result of, and in the same clinical encounteras the screening test.	$0
	Community First Choice Services (CFC)* CFC Services available to members who qualify: • Personal Assistant Services (PAS) • Day Habilitation Services (DAHS) • Emergency Response Services (ERS) • Support Management	*$0*

	Dental services Certain dental services, including cleanings, fillings, and dentures, are available through the Texas Medicaid Dental Program. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. Molina Medicare Complete Care Plus (HMO D-SNP) will pay for the following services for Non-Waiver members in the community: Preventive Dental Services: • Oral exam • Cleaning • Dental x-rays • Fluoride treatment Molina Medicare Complete Care Plus (HMO D-SNP) offers comprehensive dental benefits.* Our plan pays up to $4,000 every year for preventive and comprehensive services for Non-Waiver Members in the Community. This annual limit is for all dental services combined: preventive, comprehensive and dentures. Our plan also offers an additional $250 for dental services for non-waiver members in the community as a value added service. Contact the plan for more information. Members in a Nursing Facility are eligible for the following dental benefits: Up to $500 per year for dental exams, x-rays, and cleaning for members 21 years of age and older.	*$0*

Covered Service		What you pay
	Dental Services for waiver members - The annual cost cap of this service is $5,000 per waiver plan year. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.	
	Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0
	Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0

Covered Service		What you pay
	Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following*: o a blood glucose monitor o blood glucose test strips o lancet devices and lancets o 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. Certain diabetic supplies, including blood glucose testing products, are limited to specific brands and manufacturers. The preferred diabetic products are Trividia Health brands (TrueMetrix). The most recent list of these diabetic supplies is available on our website. • For people with diabetes who have severe diabetic foot disease, we pay for the following: o one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** o one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) o The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	$0

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies* Refer to **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We *pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area* doesn't *carry a particular brand or maker, you may ask them if they can special order it for you.*	$0

Covered Service		What you pay
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. 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: • serious risk to your life or to that of your unborn child; **or** • serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: o There isn't enough time to safely transfer you to another hospital before delivery. o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. As an added benefit, we offer up to $10,000 of worldwide emergency coverage each calendar year for emergency transportation, urgent care, emergency care, and post-stabilization care. This benefit is limited to services that would be classified as emergency or urgent care had the care been provided in the U.S. See "Worldwide emergency/urgent coverage" in this chart to learn more. .	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, *to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if* our *plan approves your stay.*

Covered Service		What you pay
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing*	*$0*

Covered Service		What you pay
	Fitness Benefit (Supplemental) You get a fitness center membership to participating fitness centers. If you are unable to visit a fitness center or prefer to also work out from home, you can select a Home Fitness kit. The kit will help you keep active in the comfort of your home. Home Fitness options include choice of fitness tracker, strength, or yoga kits. If you choose to work out at a fitness center, you can view the website and select a participating location, or you can go directly to a participating fitness center to get started. Participating facilities and fitness chains may vary by location and are subject to change. Kits are subject to change.	*$0* There is no coinsurance, copayment, or deductible for this benefit. Always talk to your doctor before starting or changing your exercise routine.
	Gas reward $15 gas reward, upon request, for currently enrolled Members in the Community to go to WIC offices, food pantries or community centers. One per year. Members may call Member Services for information about how to access these services. Members may request this benefit from the health plan by calling Member Services and/or through the Member Portal.	*$0*

Covered Service		What you pay
	Health and wellness education programs The plan offers the following health and wellness education programs: ▪ *Health Education* ▪ *24-Hour Nurse Advice Line* o *Available 24 hours a day, 7 days a week* ▪ *Telemonitoring Services* ▪ *Counseling Services* ▪ *Weight Watchers program* meeting vouchers for Members in the Community, age 21 and over, with BMI of 30 and over *Enhanced Disease Management:* ▪ *These programs are designed to help you manage certain health conditions. Some of these conditions are Asthma, Hypertension, Coronary Artery Disease, Congestive Heart Failure, COPD and Diabetes; we also have a special program to help you if you are pregnant. The programs offer learning materials, telephonic calls, and advice.* ▪ *Members with asthma or COPD who are enrolled in Molina's Case Management program for at least three months can get an allergy-free pillowcase and mattress cover and pest repellant wall plugs. Available once per year, upon request.*	*$0*

Covered Service		What you pay
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Fitting / evaluation for hearing aids can be done once every calendar year. If you are told you need hearing aids, you can get up to 2 pre-selected hearing aids from a plan-approved provider every year for both ears combined.	*$0*
	HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0

Covered Service		What you pay
	Home health agency care* Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	*$0*

Covered Service		What you pay
	Home infusion therapy **Our** plan **pays** for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	*$0*
	Home Visits* Plan covers up to an extra 8 hours respite services for non-waiver members in the community age 21 and over.	*$0*

	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to Chapter 5 of this *Member Handbook*.	

Covered Service		What you pay
	This benefit is continued on the next page	
	Hospice care (continued) **Note:** If you need non-hospice care, call your service coordinator and/or member services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis.	
🍎	**Immunizations** We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to Chapter 6 of this *Member Handbook* to learn more.	$0

Covered Service		What you pay
	Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • blood, including storage and administration • physician services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Covered Service		What you pay
	Inpatient hospital care* (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. *Transplant providers may be local or outside of the service area.* If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan *provides transplant services outside the pattern of care for* our *community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.* **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	

Covered Service		What you pay
	Inpatient services in a psychiatric hospital * We pay for mental health care services that require a hospital stay *for* members under age 21 or ages 65 and older. There isn't a day *limitation* for *services*. *All services are approved based on Medical Necessity. For example, benefit is not covered for individuals between ages 22-64 consistent with the federal provision on institutions of mental disease.* • If you're in a psychiatric hospital (instead of a general hospital), Medicare only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime. • If you used part of your 190-day lifetime limit prior to enrolling in our plan, then the number of covered lifetime hospital days is reduced by the number of inpatient days for mental health care treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. • There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital, but there's a lifetime limit of 190 days	$0

Covered Service		What you pay
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay* We don't pay for your inpatient stay if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: an internal body organ (including contiguous tissue), **or** o the function of an inoperative or malfunctioning internal body organ. • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • physical therapy, speech therapy, and occupational therapy	$0

Covered Service		What you pay
	Institution for Mental Disease (IMD) Services for Individuals 65 or Older* An institution for mental disease (IMD) is defined as an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.	$0
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of this *Member Handbook,* or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0

Covered Service		What you pay
	Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0
	Meal benefit* 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, or for a medical condition or potential medical condition that requires you to remain at home for a period of time. If you qualify, your plan Service Coordinator will enroll you in the program. You may also qualify if your doctor requests this benefit for you because of your chronic condition. 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.	$0

Covered Service		What you pay
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when *ordered* by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. (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 *order*. A doctor must prescribe these services and renew the *order* each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0
	Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Covered Service		What you pay
	Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • **This benefit is continued on the next page**	$0 Step Therapy may be required for certain drugs. Prior Authorization may be required.

Covered Service		What you pay
	Medicare Part B drugs (continued) • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug.) As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Retacrit®, Aranesp®) • **This benefit is continued on the next page**	

Covered Service		What you pay
	Medicare Part B drugs (continued) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: MolinaHealthcare.com/Medicare. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan.	

	Non-Emergency Medical Transportation (NEMT) services *The plan will pay for transportation services to non-emergency health care appointments if you have no other transportation options.* • *These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get health care services.* • *These trips **don't** include ambulance trips.* *NEMT services include:* • *passes or tickets for transportation, such as mass transit within and between cities or states (including by rail or bus)* • *commercial airline transportation services* • *demand response (curb-to-curb) transportation services in private buses, vans, or sedans (including wheelchair-accessible vehicles, if necessary)* • *mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor* • Transportation for members in a nursing facility is only covered when the member is traveling to and from a dialysis appointment or if the member is being discharged from a nursing facility to a lower level of care or home setting. You get a combined $168 every month to spend on non-emergency transportation services to plan approved health-related locations. Examples of approved plan locations are network providers for medical, pharmacy, dental, vision and hearing. This monthly allowance is shared with the allowance for Food and Produce (SSBCI)*, Over-the- Counter (OTC) items, OTC Hearing Aids, Transportation Non-Medical needs (SSBCI)*, and Utilities (SSBCI)*. If you don't use all of your monthly allowance, the remaining balance will expire and not rollover to the next month.	There is no coinsurance or copayment for these services if you are usiing your pred-funded (MyChoice) debit card. You may be responsible for costs if you exceed your maximum monthly allowance. Limitations and exclusions may apply. If you need emergency care, dial 911 and request an ambulance. Reer to "Ambulance services" in

Covered Service		What you pay
		this chart to learn more about emergency transportation.

Covered Service		What you pay
	Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Nursing facility custodial care includes semi-private room and board, nursing care, medical supplies, equipment, personal needs items, social services, and over-the-counter drugs. Additionally, add-on benefits may be provided based on medical necessity including physical therapy, occupational therapy, speech therapy, emergency dental services, emergency and non-emergency ambulance transportation, custom powered wheelchairs and augmentative communication devices. Members in a Nursing Facility can get non-emergency medical transportation to and from dialysis appointments or when being discharged from a nursing facility to a lower level of care or home setting. You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	$0

Covered Service		What you pay
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the 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

Covered Service		What you pay
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests	$0

Covered Service		What you pay
	Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unles the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits.* This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf	$0

Covered Service		What you pay
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services • Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” • Sometimes you can be in the hospital overnight and still be “outpatient.” • You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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

Covered Service		What you pay
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
	Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment	$0
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$0

Covered Service		What you pay
	Over-the-counter (OTC) items (Supplemental) You get a combined $168 every month to spend on plan-approved OTC items, products, and medications with your pre-funded debit card (MyChoice Card). Please see the pre-funded debit card (MyChoice Card) section for more information. If you don't use all of your monthly benefit amount, the remaining balance will expire and not rollover to the next month. Your coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages. Members may also use their OTC allowance for OTC hearing aids. OTC hearing aids may be purchased through catalog purchase. OTC items may be purchased through participating retail locations. For more information, contact Member Services. You can order: **Online** – visit NationsOTC.com/Molina **By Phone** – 877-208-9243 to speak with a NationsOTC Member Experience Advisor at (TTY 711), 24 hours a day, seven days a week, 365 days a year. **By Mail** – Fill out and return the order form in the product catalog. Through participating retail locations. Refer to your 2026 OTC Product Catalog for a complete list of plan-approved OTC items or call an OTC support person for more information. You will find important information (order guidelines) in the 2025 OTC Product Catalog.	There is no coinsurance or copayment if you are using your pre-funded debit card (MyChoice card). Limitations and exclusions may apply. You may be responsible for costs if you exceed your maximum monthly allowance.

Covered Service		What you pay
	Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.	$0

Covered Service		What you pay
	Personal assistance services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • grooming • eating • bathing • dressing and personal hygiene • functional living tasks / assistance with planning • preparing meals • transportation, or assistance in securing transportation • assistance with ambulation and mobility • reinforcement of behavioral support or specialized therapies activities; **and** • assistance with medications These services can be self-directed if you choose. This option allows you or your legally authorized representative to be the employer of some of your service providers and to direct the delivery of program services.	$0

Covered Service		What you pay
	Personal Emergency Response System (PERS) * *PERS is an in-home medical alarm system that can get you help in an emergency. If you qualify, you will be given a mobile, cellular, or landline device and a small pendant that should be worn at all times. The pendant can be worn on the neck, wrist, or belt. With the press of a button you will be connected to a Caring Center Representative at the monitoring company.* *Operators are available 24 hours a day, 7 days a week, and will stay on the line with you in the event of an emergency. Whether you need urgent medical service or a family member to assist you, the Caring Center Representative will get you the help you need.* *The plan covers ERS for waiver members. Prior authorization may be required.* *For Non-Waiver members, Your Service Coordinator will decide if you qualify for this benefit. Prior authorization is required.*	$0

Covered Service		What you pay
	Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office • certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment **This benefit is continued on the next page**	$0
	Physician/provider services, including doctor's office visits (continued) • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder **This benefit is continued on the next page**	

	Physician/provider services, including doctor's office visits (continued) • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if** o you're not a new patient **and** o the check-in isn't related to an office visit in the past 7 days **and** o the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: o you're not a new patient and o the evaluation isn't related to an office visit in the past 7 days **and** o the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment **This benefit is continued on the next page**	

Covered Service		What you pay
	Physician/provider services, including doctor's office visits (continued) • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinionby another network provider before surgery	
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	$0
	Podiatry services (Supplemental) You don't need an underlying condition to take advantage of this benefit. Coverage includes general foot care such as corn and callousremoval, cutting of toenails, treatment of cracked skin, and other foot problems. Plan maximum of up to 6 supplemental routine foot care visits every calendar year.	There is no coinsurance or copayment for each podiatry visit. Prior authorization may be required.

Covered Service		What you pay
	Postpartum Support • **Infant car seat** One infant car seat reward for currently enrolled members in the sixth month of pregnancy through six months following delivery. Available upon request. • **Postpartum kit** Available to currently enrolled members, upon request, for up to three months following delivery. Available once every year.	
🍎	**Pre-exposure prophylaxis (PrEP) for HIV prevention** If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	

Covered Service		What you pay
	Pre-funded debit card (MyChoice card) You receive a pre-funded debit card that may be used toward select supplemental plan benefits such as: • Food and produce* • Utilities* • Over-the-Counter items • OTC Hearing Aids • Transportation (Non-Emergency Medical) • Transportation Non-Medical Needs* Funds are loaded onto the card each month. At the end of each month, any unused allocated funds will not carry over to the following month or plan year. If you don't use all of your monthly benefit amount, the remaining balance will expire and not rollover to the next benefit period. OTC hearing aids may be purchased through catalog purchase. *Eligibility requirements applicable	$0
🍎	**Prostate cancer screening exams** For men aged 50 and older, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0

Covered Service		What you pay
	Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • 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) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	$0
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0

Covered Service		What you pay
	Pyx Health Members in both the Community and Nursing Facility receive 24/7 access to support, resources, and tools for managing loneliness, stress and other challenges through telephone and mobile app based resource. Must be currently enrolled. "Pyx Health" App can be found in the App Store for iPhone users or Google Play for Android users.	$0
	Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	

Covered Service		What you pay
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

	Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12.** We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled 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 • The plan will pay for whole blood and packed red cells beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. • The plan will pay for all other parts of blood beginning with the first pint used. • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services • For newly enrolled nursing facility members within 30 days of confirmed enrollment, members recieve a wheelchair/walker accessory tote bag, non-slip socks,	$0

Covered Service		What you pay
	personal blanket, one large print digital clock, and combined cup and phone holder. Available one time only. • Nursing facility members who are diagnosed with Alzheimer's can get a Photo Remembrance Album upon request. Available only one time. • **This benefit is continued on the next page**	
	Skilled nursing facility (SNF) care (continued) You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	

Covered Service		What you pay
	Smoking and tobacco use cessation Smoking and tobacco use cessation counseling is covered for outpatient and hospitalizedpatients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-relateddisease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year). The plan also offers tobacco cessation counseling for pregnant women.	$0

Covered Service		What you pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0

Covered Service		What you pay
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseeen illness, **or** • an injury, **or** • a condition that needs care right away. 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 can't get to a network provider beause given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). Medical services performed out of the country aren't covered by Medicaid.	$0

Covered Service		What you pay
	Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans • Hispanic Americans For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.	$0

Covered Service		What you pay
	Vision care (Supplemental) * We have partnered with a Vision Vendor to give you more value for your routine vision needs! Supplemental Vision services covered include, but not limited to: Coverage includes: • One routine eye exam every calendar year • An eyewear allowance You can use your $250 eyewear allowance to purchase: • Contact lenses* • Eyeglasses (lenses and frames) • Eyeglass lenses and / or frames • Upgrades (such as, tinted, U-V, polarized or photochromatic lenses) *If you choose contact lenses, your eyewear allowance can also be used to pay down all or a portion of your contact lensfitting fee. You are responsible or paying for any corrective eyewear over the limit of the plan's eyewear allowance. $0 copay for up to one routine eye exam (and refraction) for eyeglasses every calendar year.	$0

Covered Service		What you pay
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

D1. Our home and community-based services

In addition to these general services, our plan also covers home and community-based services. These are services that you may be able to use instead of going to a facility. To get some of these services, you'll **need to qualify for the home and community-based waiver (the STAR+PLUS Waiver). Your Service Coordinator will work with you to decide if these services are right for you and will be in your Plan of Care.**

Community-based services that our plan covers	What you pay
Adaptive* aids *and* medical supplies *The plan covers the following devices, controls, appliances, or items that are necessary to address your specific needs, including those necessary for life support up to a $10,000 per year limit.* The plan may pay for the following if medically or functionally necessary, and maybe other items/services not listed here: • lifts, including vehicle lifts • mobility aids • positioning devices • control switches/pneumatic switches and devices • environmental control units • medically necessary supplies • communication aids (including batteries) • adaptive/modified equipment for activities of daily living • safety restraints and safety devices *Case managers can help you get medical supplies or equipment.*	$0

Community-based services that our plan covers	What you pay
Adult foster care* The plan covers 24-hour living arrangements in a foster home if you have physical, mental, or emotional limitations or if you're unable to continue functioning independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • meal preparation • housekeeping • personal care • nursing tasks • supervision • companion services • daily living assistance • transportation	$0

Community-based services that our plan covers	What you pay
Assisted living services* The plan covers a 24-hour living arrangement for you if you're unable to live independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Host home/companion care that provides you with: o personal assistance o functional living tasks o supervision of your safety and security o habilitation activities • Supervised living that provides you with: o personal assistance o functional living tasks o supervision of your safety and security o habilitation activities • Residential support service that provides you with: o personal assistance o functional living tasks	$0
Cognitive rehabilitation therapy* The plan covers services that help you learn or re-learn cognitive skills. These skills may have been lost or altered as a result of damage to brain cells or brain chemistry.	$0

Community-based services that our plan covers	What you pay
• **Day habilitation services*** • These services help you with obtaining, retaining, or improving skills necessary to live successfully at home and/or in community-based settings. • They promote independence, personal choice, and achievement of the outcomes identified in your service plan.	$0
***Dental* services** The plan covers the following services to help preserve your teeth and meet your medical needs up to $5,000 per year. If the services of an oral surgeon are required, you can get an additional $5,000 per year. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • emergency dental treatment • preventive dental treatment • therapeutic dental treatment (restoration, maintenance, etc.) • orthodontic dental treatment	$0
Emergency* response services *The plan covers emergency response services for you through an electronic monitoring system 24 hours a day, 7 days a week.* *In an emergency, you can press a call button to signal for help.*	$0

Community-based services that our plan covers	What you pay
Employment* assistance The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • identifying your employment preferences, job skills, and requirements for a work setting and work conditions • locating prospective employers offering employment compatible with your identified preferences, skills, and requirements • contacting a prospective employer on your behalf and negotiating your employment • transportation • participating in service planning team meetings	$0
• **Functional living task services*** • These services help you with: • planning and preparing meals • transportation, or help in securing transportation • assistance with ambulation and mobility • reinforcement of behavioral support or specialized therapies activities • assistance with medications	$0
Home-Delivered* meals *The plan covers hot, nutritious meals that are served in your home. Meals are limited to 1 to 2 per day.*	$0

Community-based services that our plan covers	What you pay
Minor* home modifications The plan covers minor home modifications to ensure your health, welfare, and safety and to allow you to function with greater independence in your home. The plan will cover up to $7,500 over the course of your lifetime and will also cover up to $300 each year for repairs. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • installation of ramps and grab bars • widening of doorways • modifications of kitchen and bathroom facilities, and • other specialized accessibility adaptations	$0
***Nursing* services** *The plan covers the treatment and monitoring of your medical conditions, especially if you have chronic conditions that require specific nursing tasks.*	$0

Community-based services that our plan covers	What you pay
Occupational* therapy *The plan covers occupational therapy for you, which provides assessment and treatment by a licensed occupational therapist.* The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • screening and assessment • development of therapeutic treatment plans • direct therapeutic intervention • assistance, and training with adaptive aids and augmentative communication devices • consulting with and training other service providers and family members • participating on the service planning team, when appropriate	$0

Community-based services that our plan covers	What you pay
***Personal* assistance services** *The plan covers personal assistance with activities of daily living.* The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • grooming • eating • bathing • dressing and personal hygiene • functional living tasks / assistance with planning • preparing meals • transportation or assistance in securing transportation • assistance with ambulation and mobility • reinforcement of behavioral support or specialized therapies activities; **and** • assistance with medications	$0

Community-based services that our plan covers	What you pay
Physical* therapy *The plan covers physical therapy, assessments, and treatments by a licensed physical therapist.* The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • screening and assessment • development of therapeutic treatment plans • direct therapeutic intervention • assistance and training with adaptive aids/augmentative communication devices • consulting with and training other service providers and family members • participating on the service planning team, when appropriate	$0

Community-based services that our plan covers	What you pay
Respite* care The plan may pay for the following services if medically or functionally necessary up to 30 visits a year, and maybe other services not listed here: • personal assistance • habilitation activities • community activities • leisure activities • supervision of your safety and security • development of socially valued behaviors • development of daily living skills *Respite care is provided to ensure your comfort, health, and safety. It* may be provided in the following locations: your home or place of residence; adult foster care home; Texas Medicaid certified nursing facility; and an assisted living facility.	$0
Speech,* hearing*, and* language therapy The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • screening and assessment • development of therapeutic treatment plans • direct therapeutic intervention • assistance/training with adaptive aids and augmentative communication devices • consulting with and training other service providers and family members • participating on the service planning team, when appropriate	$0

Community-based services that our plan covers	What you pay
Support* consultation *The plan covers optional support consultation provided by a chosen certified support advisor.* *This advisor will assist you in learning about and performing employer responsibilities.* The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • recruiting, screening, and hiring workers • preparing job descriptions • verifying employment eligibility and qualifications, and other documents required to employ an individual • managing workers • other professional skills as needed	$0
***Supported* employment** *The plan covers supported employment, which is provided to you at your place of employment if:* • you need the support services to maintain employment due to a disability; • you're paid minimum wage (or more) for the work performed; **and** • your place of employment is competitive and integrated. The plan also covers transportation to and from your worksite, and supervision and training to you beyond what an employer would ordinarily provide.	$0

Community-based services that our plan covers	What you pay
***Transitional* assistance services** *The plan covers one transition from a nursing facility to a home in the community, up to a $2,500 limit.* The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • payment of security deposits required to lease an apartment or home • set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water • purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens • payment of moving expenses required to move into or occupy the home or apartment; **and** • payment for services to ensure your health in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy	$0

F. Benefits covered outside of our plan

We don't cover the following services, but they're available through Medicare or Fee-For-Service Medicaid.

F1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Hospice programs provide members and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Molina Medicare Complete Care Plus (HMO D-SNP) 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 and any Medicare Part A or B services. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

- 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 Medicare Complete Care Plus (HMO D-SNP)'s **Medicare Part D benefit:**

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5.

Note: If you need non-hospice care, you should call your Service Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

F2. Pre-Admission Screening and Resident Review (PASRR)

This is a program to ensure members are not inappropriately placed in nursing homes. This requires that members (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) get the services they need in those settings.

F3. Cytogenomic Constitutional Microarray Testing

Cytogenomic Constitutional Microarray testing is covered one per lifetime.

G. Benefits not covered by our plan, Medicare, STAR+PLUS, or Fee-For-Service Medicaid

This section tells you about benefits excluded by our plan. “Excluded” means that we don’t pay for these benefits. Medicare and Medicaid don’t pay for them either.

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

We don’t pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won’t pay for the services. If you think that our plan should pay for a service that isn’t covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

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

- services considered not “reasonable and medically necessary”, according Medicare and STAR+PLUS standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this Member Handbook for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary

- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in Section D
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.

Chapter 5: Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient 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 STAR+PLUS.. *Key terms and their definitions appear in alphabetical order in the last chapter of* this *Member Handbook.*

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're 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're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5**, **Section D** "If you're in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

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

- You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information). *Or you can fill your prescription through the plan's mail-order service.*
- Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short. (Refer to **Section** B of this chapter.)
    - If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.

  - Refer to **Chapter 9** to learn about asking for an exception.

- Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.
- Your drug may require approval from our plan based on certain criteria before we'll cover it. (*Refer to Section C* in this chapter.)

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Member Services *or your* care coordinator.

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 bills us for your covered drug.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If **the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up**. Then you can ask us to pay you back. If you **can't** pay for the drug, contact Member Services right away. We'll do everything we can to help.

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

A3. What to do if you change your network pharmacy

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

If you need help changing your network pharmacy, contact Member Services *or your* service coordinator.

A4. What to do if your pharmacy leaves the network

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

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services *or your* service coordinator.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
    - Usually, long-term care facilities have their own pharmacies. If you 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 dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.) To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A6. Using mail-order services to get your drugs

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

Our plan's mail-order service *allows* you to order *at least a 31-day supply of the drug and no more than a 100-day supply*. A 31-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get *order forms and* information about filling your prescriptions by mail, *please call Member Services at (*866) 856-8699*, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time or you can visit* MolinaHealthcare.com/*Duals*.

Usually, a mail-order prescription arrives within 14 days. *Please call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time if your mail-order is delayed.*

Mail-order processes

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

1. New prescriptions the pharmacy gets from you

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

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

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

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

3. Refills on mail-order prescriptions

For refills, contact your pharmacy 14 days before your current prescription runs out to make sure your next order is shipped to you in time.

4. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.

Let the pharmacy know the best ways to contact you so they 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 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 31-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your service coordinator or Member Services for more information.

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. *We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan.* In these cases, check with your service coordinator or Member Services first to find out if there's a network pharmacy nearby.

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

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

A9. Paying you back for a prescription

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

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

B. Our plan's *Drug List*

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

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

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

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D and some prescription *and over-the-counter* (OTC) drugs *and* products covered under STAR+PLUS.

Our *Drug List includes brand name drugs, generic drugs, and* biological products (which may include *biosimilars*).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. *Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.*

Refer to Chapter 12 for definitions of the types of drugs that may be on the Drug List.

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

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

B2. How to find a drug on our *Drug List*

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

- Check the most recent *Drug List* we sent you in the mail.
- Visit our plan's website at MolinaHealthcare.com/Medicare. The *Drug List* on our website is always the most current one.
- Call your service coordinator or Member Services to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at https://www.caremark.com or call Member Services. With this tool you can search for drugs on the *Drug List* to get an

estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call your care coordinator/service coordinator or Member Services.

- Ask your Service Coordinator to find out if a drug is on the plan's *Drug List*.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List.* For more information refer to **Chapter 9.**

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

Here are three general rules for excluded drugs:

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

Also, by law, Medicare or STAR+PLUS can't cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for the treatment of anorexia, weight loss or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. *Drug List* cost-sharing tiers

Every drug on our *Drug List* is in one of six (6) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

Tier 1: Preferred generic

Tier 2: Generic name

Tier 3: Preferred brand

Tier 4: Non-Preferred

Tier 5: Specialty

Tier 6: Select Care

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

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

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

Note that sometimes a drug may appear more than once in our *Drug List.* This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

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

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

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

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

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

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

1. **Limiting use of a brand name drug or original biological products when, *respectively,* a generic or interchangeable biosimilar version is available**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. If there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

   - We usually don't pay for the brand name drug or original biological product when there's an available generic version.
   - However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you or wrote "No substitutions" on your prescription for a brand name drug or original biological product or told us the medical reason that the generic drug interchangeable biosimilar or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at MolinaHealthcare.com/Medicare for more information about prior authorization.

You can get a 72-hour supply of a drug covered by Texas Medicaid if it is an emergency.

3. Trying a different drug first

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

If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at MolinaHealthcare.com/Medicare for more information about step therapy.

3. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Member Services or check our website at MolinaHealthcare.com/Medicare. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Member Handbook.*

D. Reasons your drug might not be covered

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

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name

version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

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

D1. Getting a temporary supply

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

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

1. The drug you've been taking:
    - is no longer on our *Drug List* **or**
    - was never on our *Drug List* **or**
    - is now limited in some way.
2. You must be in one of these situations:
    - You were in the plan last year.
        - *We cover a temporary supply of your drug* ***during the first 90 days of the calendar year****.*
        - *This temporary supply* is *for up to 31 days.*
        - *If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 31 days of medication.* You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
    - You're new to our plan.
        - We cover a temporary supply of your **drug during the first *90* days of your membership in our plan.**

- This temporary supply is for up to *31 days*.
- *If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 31 days of medication.* You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

- You've been in our plan for more than *90* days, live in a long-term care facility, and need a supply right away.
  - We cover one *31*-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - 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.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

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

- Change to another drug.

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

  OR

- Ask for an exception.

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

If a drug you 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.

D3. Asking for an exception

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

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

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

If you need help asking for an exception, contact Member Services *or your* service coordinator.

E. Coverage changes for your drugs

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

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List.* For more information on these drug rules, refer to Section C.

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

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

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

- Check our current *Drug List* online at MolinaHealthcare.com/Medicare or
- Call Member Services to check the current *Drug List* at 866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.

Changes we may make to the *Drug List* that affect you during the current plan year

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

- **A new generic drug becomes available.** Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product 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'll 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'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.

Some changes to the Drug List may include:

- ***A new generic drug*** or interchangeable biosimilar ***becomes available.*** *Sometimes, a new generic drug or an interchangeable biosimilar version of the same biological product comes on the market that works as well as a brand name drug or original biological product on the Drug List now. When that happens, we may remove the brand name drug or original biological product and add the new generic drug: or an interchangeable biosimilar version of the same biological product, but your cost for the new drug : or an interchangeable biosimilar will stay the same.*

  When we add the new generic drug, we may also decide to keep the brand name drug or original biological product on the list but change its coverage rules or limits.

  When these changes happen, we'll*:*

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

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

  - *If you should switch to the generic or interchangeable biosimilar or if* there's *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, refer to Chapter 9.*

- **Removing unsafe drugs and other drugs that are taken off the market**. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. Contact your prescribing doctor if you receive a notification.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our *Drug List* **or**

- Let you know and give you a 31-day supply of the drug after you ask for a refill.

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

- If there's a similar drug on our *Drug List* you can take instead or
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the *Drug List* that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you above these types of changes directly during the current year. You'll need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

F. Drug coverage in special cases

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

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

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's 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 isn't or if you need more information, contact Member Services.

F3. In a Medicare-certified hospice program

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

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

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

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

- may not be needed because you take another similar 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
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

Then, they'll give you:

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

It's a good idea to talk to your prescriber about your action plan and medication list.

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

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Member Services *or your* service coordinator.

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications **from** a **certain** pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications **from a certain** prescriber(s)
- Limiting **the amount** of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Member Handbook*.)

The DMP may not apply to you if you:

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

- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and STAR+PLUS drugs

Introduction

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

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you’re eligible for STAR+PLUS, you get Extra Help from Medicare to help pay for your Medicare Part D drugs.

> **Extra Help** is a 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.”

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

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

- Our *List of Covered Drugs.*
  - We call this the Drug List. It tells you:
    - Which drugs we pay for
    - Which of the six (6) tiers each drug is in
    - If there are any limits on the drugs
      - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at MolinaHealthcare.com/Medicare.
- **Chapter 5** of this *Member Handbook*.
  - It tells how to get your outpatient drugs through our plan.

- It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
- When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call your service coordinator or Member Services for more information.

- Our *Provider and Pharmacy Directory.*
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* more information about network pharmacies.

The Explanation of Benefits (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs***.* This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits.* We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.

- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives.** When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our *Drug List*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under STAR+PLUS. These drugs are included in the *Drug List*.

How to keep track of your drug costs

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

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

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

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

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

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

   For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.

3. **Send us information about payments others** make **for you.**

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a state pharmaceutical assistance program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

When you get an *EOB* in the mail, make sure it's complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Molina Healthcare Member Services. You can also find answers to many questions on our website: Molina Medicare Complete Care Plus (HMO- DSNP).

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Molina Medicare Complete Care Plus (HMO- DSNP) Member Services.
- 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.
- You can also call Texas Health and Human Services Office of the Inspector General to submit a complaint at 1-800-447-8477.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They're an important record of your drug expenses.

Drug Payment Stages for Medicare Part D drugs

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

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through end date. You begin this stage when you've paid a certain amount of out-of-pocket costs.

C1. Our plan has 6 cost sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our Drug List is in one *of* six (6) cost-sharing tiers. In general, the higher the tier number, the higher the copay. *To find the* cost-sharing *tiers for your drugs,* refer to our *Drug List.*

Tier 1: Preferred generic

Tier 2: Generic name

Tier 3: Preferred brand

Tier 4: Non-Preferred

Tier 5: Specialty

Tier 6: Select Care

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 100-day supply. It costs you the same as a one-month supply.

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

C3. **What you pay**

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month supply of a covered drug from:	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	*$0*	*$0*	*$0*	*$0*

Your share of the cost when you get a one-month supply of a covered drug from:	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 2 (Generic)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

Your share of the cost when you get a one-month supply of a covered drug from:	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 3 (Preferred Brand)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

Your share of the cost when you get a one-month supply of a covered drug from:	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 4 (Non-Preferred Drug)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

Your share of the cost when you get a one-month supply of a covered drug from:	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 5 (Specialty Tier)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

Your share of the cost when you get a one-month supply of a covered drug from:	**A network pharmacy** A one-month or up to a 31-day supply	**Our plan's mail-order service** A one-month or up to a 31-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 31-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 6 (Select Care Drugs)	$0	$0	$0	$0

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

Stage 1: The Initial Coverage Stage

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

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's *Drug List* is in one of 6 cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our *Drug List*.

Tier 1: Preferred generic

Tier 2: Generic name

Tier 3: Preferred brand

Tier 4: Non-Preferred

Tier 5: Specialty

Tier 6: Select Care

D1. Your pharmacy choices

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

- A network retail pharmacy **or**
- An out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.
- Our plan's mail-order pharmacy.

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

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100 day supply. It may cost you the same as a one-month supply.

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

D3. What you pay

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

Contact Member Services to find out how much your copay is for any covered drug.

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

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 100-day supply	**An out-of-network pharmacy** Up to a 100-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	*$0*	*$0*	*$0*	*$0*
Cost-sharing Tier 2 (Generic)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 100-day supply	**An out-of-network pharmacy** Up to a 100-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 3 (Preferred Brand)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 100-day supply	**An out-of-network pharmacy** Up to a 100-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 4 (Non-Preferred Drug)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 100-day supply	**An out-of-network pharmacy** Up to a 100-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 5 (Specialty Tier)	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.	$0, $1.60, or $5.10 copay for generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs per prescription.
Cost-Sharing Tier 6 (Select Care Drugs)	$0	$0	$0	$0

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $2100. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the *insert as applicable:* $2100 limit. Many people don't reach it in a year.

Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2100 for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

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

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

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment is less than $.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.

- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:

  Better plan when to refill your drugs,

  Coordinate refills with other drugs you take, **and**

  Take fewer trips to the pharmacy.

What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *Drug List* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

The first part is for the cost of **the vaccine itself**.

The second part 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.

G1. What you need to know before you get a vaccine

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

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

Chapter 7: Asking us to pay a bill you got 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 don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

A. Asking us to pay for your services or drugs

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

We don't allow Molina Medicare Complete Care Plus (HMO D-SNP) providers to bill you for these services drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to Section B.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid, it's your right to be paid back.
  - » If you paid for services covered by Medicare, we'll pay you back.
  - » If you paid for services covered by STAR+PLUS, we can't pay you back, but the provider will. Member Services or *service coordinator.* can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we don't cover the services or drugs, we'll tell you.

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

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

5. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - o If the provider should be paid, we'll pay the provider directly.

- If you already paid for the Medicare service, we'll pay you back for our share of the cost.

6. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call Member Services** or your service coordinator at the number at the bottom of this page **if you get any bills.**

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

If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

7. When you use an out-of-network pharmacy to fill a prescription

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

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to Chapter 5 of this *Member Handbook* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

8. When you pay the full prescription cost because you don't have your Member ID Card with you

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

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to Chapter 9 of this *Member Handbook*).
    - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to Chapter 9 of this *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for our share of the cost of it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to Chapter 9 of this *Member Handbook*.

B. Sending us a request for payment

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

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

For Medical Services:

Molina Medicare Complete Care Plus (HMO D-SNP)

P.O. Box 182273

Chattanooga, TN 37422

For Part D/Medicaid (Rx) Services:

Molina Medicare Complete Care Plus (HMO D-SNP)

7050 Union Park Center, Suite 600

Midvale, UT 84047

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

C. Coverage decisions

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

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay for it. If you already paid for the service or drug, we'll mail you a check for *what you paid*. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

- **Chapter 3** of this *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of this *Member Handbook* explains the rules for getting your Medicare Part D drugs covered.
    - If we decide not to pay for our share of the cost of the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
    - To learn more about coverage decisions, refer to Chapter 9.

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 don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Member Handbook*.

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

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

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

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call service coordinator or Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials *in languages other than English including Spanish and* in formats such as large print, braille, or audio.
    - To get materials in one of these alternative formats, please call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.
    - To change a standing request, call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time.

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

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call Medicaid at 1-866-566-8989.
- If you would like to make your complaint in writing, please send it to the following address:

➔ **Texas Civil Rights Health and Human Services Commission**
➔ Ombudsman for Managed Care
➔ P.O. Box 13247
➔ Austin, TX 78711-3247
➔

- If you can get on the Internet, you can submit an online complaint by visiting: hhs.texas.gov/managed-care-help.
- Office at 1-888-388-6332.

- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

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

➔ Debemos garantizar que **todos** los servicios se proporcionen de manera culturalmente competente y accesible. También debemos informarle acerca de los beneficios del plan y sus derechos de una manera que pueda entender. Debemos informarle acerca de sus derechos cada año que esté en nuestro plan.

- Para obtener información de una forma que sea comprensible para usted, llame al Departamento de Servicios para Miembros. Nuestro plan ofrece servicios de intérprete gratuitos para responder a preguntas en distintos idiomas.
- Nuestro plan también le puede brindar materiales en idiomas distintos al inglés, como el español y en formatos como letra grande, sistema braille o audio.
    - Para solicitar su idioma preferido distinto del inglés o un formato alternativo, llame al Departamento de Servicios para Miembros al (866) 856-8699, TTY: 711, lunes – viernes, 8 a.m. a 8 p.m. hora local.
    - Mantendremos un registro de las preferencias de idiomas o de formato de nuestros miembros y conservaremos esta información como una solicitud permanente para futuras comunicaciones y envíos por correo. Esto garantizará que nuestros miembros no tengan que realizar una solicitud independiente cada vez.
    - Para cambiar una solicitud permanente, llame al Departamento de Servicios para Miembros al (866) 856-8699, TTY: 711, lunes – viernes, 8 a.m. to 8 p.m. hora local.

➔ Si tiene problemas para obtener información de nuestro plan debido a problemas con el idioma o una discapacidad y desea presentar una queja, llame a

- Medicare al 1-800MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.
- Puede presentar una queja con la Comisión de Salud y Servicios Humanos (HHSC, por sus siglas en inglés) llamando gratuitamente al 1-866-566-8989.
- Si desea presentar su queja por escrito, por favor envíela a la siguiente dirección:

➔ Texas Health and Human Services Commission
➔ Ombudsman Managed Care Assistance Team
➔ P.O. Box 13247
➔ Austin, TX 78711-3247
➔

- Si usted tiene acceso al internet, puede enviar su queja por correo electrónico al: hhs.texas.gov/managed-care-help
- Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Our responsibility for your timely access to covered services and drugs

➔ If you have a hard time getting care, contact Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time. We will work with you to refer you to another provider. If necessary, we may also refer you to out-of-network care if we cannot provide the service within our network.

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in Chapter 3 of this *Member Handbook*.
  - Call your service coordinator or Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
  - Be told how to choose and change your health plan and your PCP.
  - Choose any health plan you want that is available in your area and choose your PCP from that plan.
  - Be told the frequency you can change plans.
  - Be told about other plans available in your area.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.

- You can get services such as those listed below without getting approval in advance from your PCP:
  - Behavioral Health Services from a network provider.
  - Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
  - Any services for Emergency Conditions (which includes emergency Behavioral Health Service).
  - Family planning services.
  - Network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery.
  - Sexually Transmitted Disease (STD) services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment.
  - Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)
  - You have access to seventy-two (72) hour emergency supplies of non-Part D prescription drugs.
- 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.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.

- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3 of this *Member Handbook*.
- You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  - Work as part of a team with your provider in deciding what health care is best for you.
  - Say yes or no to the care recommended by your provider.
- You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
  - Get medical care in a timely manner.
  - Get in and out of a health care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
  - Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
  - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

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

Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

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

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

C1. How we protect your PHI

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

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

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

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

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

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 to 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 (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m., local time.**

NOTICE OF PRIVACY PRACTICES

MOLINA HEALTHCARE OF TEXAS

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 Texas ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") uses and shares protected health information about you to provide your health benefits as a Molina Duals 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, 2015.

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.

Why does Molina use or share your PHI?

We use or share your PHI to provide you with health care benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Address Member needs, including solving complaints and grievances.

We will share your PHI with other companies ("**business associates**") that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment, or other health-related benefits and services.

When can Molina use or share your PHI without getting written authorization (approval) from you?

In addition to treatment, payment and health care operations, the law allows or requires Molina to use and share your PHI for several other purposes including the following:

Required by law

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight

Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases, such as when approved by a privacy or institutional review board.

Legal or Administrative Proceedings

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

Law Enforcement

Your PHI may be used or shared with police for law enforcement purposes, such as to help find a suspect, witness or missing person.

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions.

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 (866) 856-8699, Monday-Friday, 8 a.m. to 8 p.m. local time. TTY users, please call 711.

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

You may complain to Molina and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care and benefits will not change in any way.

You may file a complaint with us at:

Molina Healthcare of Texas

Attention: Director of Member Services

2200 Highway 121, Suite 270A

Bedford, TX 76021

Phone: (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m. local time

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

U.S. Department of Health and Human Services

Office for Civil Rights – Centralized Case Management Operations

200 Independence Ave., S.W.

Suite 515F, HHH Building

Dallas, TX 75202

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

(202) 619-3818 (FAX)

What are the duties of Molina?

Molina is required to:

- Keep your PHI private;
- Give you written information such as this on our duties and privacy practices about your PHI;
- Provide you with a notice in the event of any breach of your unsecured PHI;
- Not use or disclose your genetic information for underwriting purposes;
    - Follow the terms of this Notice.

This Notice is Subject to Change

Molina reserves the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information

If you have any questions, please contact the following office:

Molina Healthcare of Texas

Attention: Director of Member Services

2200 Highway 121, Suite 270A

Bedford, TX 76021

Phone: (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m. local time

Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. We can also give you this document in other languages, including Spanish. We can also give you information in large print, braille, or audio. Please contact Member Services at (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m. local time to request materials in a language other than English or in an alternate format.

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

- How to choose or change plans
- Our plan, including:
    - » financial information
    - » how plan members have rated us
    - » the number of appeals made by members

    - how to leave our plan

- Our network providers and our network pharmacies, including:
    - how to choose or change primary care providers
    - qualifications of our network providers and pharmacies
    - how we pay providers in our network
- Covered services and drugs, including:
    - services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
    - limits to your coverage and drugs
    - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
    - put in writing why something isn't covered
    - change a decision we made
    - pay for a bill you got

Inability of network providers to bill you directly

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

Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.

- Refer to **Chapter 10** of this *Member Handbook:*
  - » For more information about when you can join a new MA or drug benefit plan.
  - » For information about how you'll get your STAR+PLUS benefits if you leave our plan.

Your right to make decisions about your health care

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

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

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

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

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

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

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

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

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

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

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Texas Health and Human Services Commission Complaint and Incident Intake.

To report complaints, call 800-458-9858 Monday through Friday from 7 a.m.-7 p.m., email hfc.complaints@hhs.texas.gov, or visit the Texas Health and Human Services Commission Complaint and Incident Intake website (www.hhs.texas.gov/services/your-rights/complaint-incident-intake).

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

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

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

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

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Member Services.
- The Health Information Counseling & Advocacy Program of Texas (HICAP) program at 800-252-9240. For more details about HICAP, refer to **Chapter 2**.
- The Texas Health and Human Services Office of the Ombudsman at 866-566-8989. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.

Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf).

Your responsibilities as a plan member

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

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
    - » Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
    - » Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or rug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - o Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - o Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - o Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - » Medicare Part A and Medicare Part B premiums. For most plan name members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.

- » **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call your service coordinator or Member Services.
  - » **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* tells about our service area.
  - » We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
  - » Tell Medicare and STAR+PLUS your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and STAR+PLUS.
  - » **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - » **If you move, tell Social Security (or the Railroad Retirement Board).**

Member rights and responsibilities

Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care Provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your Primary Care Provider.

b. Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.

c. Change your Primary Care Provider.

d. Change your health plan without penalty.

e. Be told how to change your health plan or your Primary Care Provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.

   b. Be told why care or services were denied and not given.

   c. Be given information about your health, plan, services providers.

   d. Be told about your rights and responsibilities.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

   a. Work as part of a team with your provider in deciding what health care is best for you.

   b. Say yes or no to the care recommended by your Provider.

5. If your MCO offers In-Lieu-Of Services and Settings, you have the right to:

   a. Be given information about the In-Lieu-Of Services and Settings you can get and how to request them.

   b. Be told why any In-Lieu-Of Services and Settings were reduced or denied.

   c. Choose to refuse to receive In-Lieu-Of Services and Settings instead of other Covered Services.

6. You have the right to use each Complaint and appeal process available through the Managed Care Organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

   a. Make a Complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan.

b. Get a timely answer to your complaint.

c. Use the plan's appeal process and be told how to use it.

d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

7. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

   b. Get medical care in a timely manner.

   c. Be able to get in and out of a health care Provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

   e. Be given information you can understand about your health plan rules, including the Health Care Services you can get and how to get them.

8. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do, or is to punish you.

9. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a Covered Service.

10. You have a right to know that you are not responsible for paying for Covered Services, Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for Covered Services.

11. You have a right to make recommendations to your health plan's member rights and responsibilities.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a Primary Care Provider quickly.
    c. Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your Primary Care Provider first for your non-emergency medical needs.
    g. Be sure you have approval from your Primary Care Provider before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your Primary Care Provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

a. Work as a team with your provider in deciding what health care is best for you.

b. Understand how the things you do can affect your health.

c. Do the best you can to stay healthy.

d. Treat providers and staff with respect.

e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Call your service coordinator or Member Services for help if you have questions or concerns.

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

Introduction

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

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

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

If you're facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your Plan of Care. **If you're having a problem with your care or Long-Term Services and Supports, you can call the HHSC Ombudsman's Office at 1-866-566-8989 for help.** This chapter explains the options you have for different problems and complaints, but you can always call the HHSC Ombudsman's Office to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** for more information on ombudsman programs.

What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

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

For example, we say:

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

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

Where to get help

B1. For more information and help

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

Help from the Health Information Counseling & Advocacy Program (HICAP).

You can also get help from HICAP. HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP isn’t connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-252-3439.

Help and information from Medicare

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

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from STAR+PLUS

If you need help with STAR+PLUS Medicaid services, contact:

Texas Medicaid Client Hotline

- Call 1-800-252-8263. TTY users call 7-1-1 or Relay Texas
- Visit HHSC website at www.hhs.texas.gov

Quality Improvement Organization (QIO), for Medicare appeal reviews:

- Call Acentra Health, Texas' Beneficiary and Family Centered Care–Quality Improvement Organization (BFCC-QIO): 1-888-315-0636
- Visit Acentra health website at www.acentra.com

Texas HHS Office of the Ombudsman, for help with complaints or resolving problems

- Call 1-866-566-8989, TTY users call 7-1-1 or Relay Texas
- Visit HHS Office of the Ombudsman website at www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman

Understanding Medicare and STAR+PLUS complaints and appeals in our plan

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

Sometimes Medicare and STAR+PLUS processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a STAR+PLUS benefit. **Section F4** explains these situations.

Problems with your benefits

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

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as **medical care.**

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4**, **Section H** of this *Member Handbook).*

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or STAR+PLUS. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or STAR+PLUS service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and STAR+PLUS, the letter will give you information regarding both types of Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **The Health Information Counseling & Advocacy Program (HICAP).** The HICAP phone number is 1-800-252-3439.
- **The Texas Health and Human Services (HHS) Ombudsman's Office.** The HHS Ombudsman's Office helps people enrolled in STAR+PLUS with service or billing problems. The phone number is 1-866-566-8989.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.

- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf *or on our website at* https://www.molinahealthcare.com/members/tx/mem/medicare/plan-materials.aspx. The form gives the person permission to act for you. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

If you need other help or information, please call the HHSC Ombudsman's Office at 1-866-566-8989.

Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: (866) 856-8699, TTY: 711, Monday - Friday, 8 a.m. to 8 p.m. local time.
- Faxing: (844) 251-1451.
- Writing: Attn: Medicare Utilization Management 200 Oceangate, Suite 100 Long Beach CA 90802.

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within**:**

- **3 calendar days** after we get your request **for a medical service or item that's subject to our prior authorization rules**
- **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

*If you think we **shouldn't** take extra days, you can make a "fast complaint**" about** our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.*

Fast coverage decision

> The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request for a **Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
    - We automatically give you a fast coverage decision if your doctor asks for it.
    - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If **we say** No **to part or all of your request**, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an **appeal,** you, your doctor, or your representative must contact us. Call us at *(866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time*.

Ask for a standard appeal or a fast appeal in writing or by calling us at *(866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time*.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://www.molinahealthcare.com/members/tx/mem/medicare/plan-materials.aspx .
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:

- We dismiss your request, and
- We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.

- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration".**

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we're stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.

- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
    - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
    - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
    - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
    - If we need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
    - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Texas a Fair Hearing is called Level 2 Appeal.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
    - If we need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
        - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
- If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about a STAR+PLUS service or item, you can ask for a Level 2 Appeal (known as a Fair Hearing) with the Texas Health and Human Services Commission (HHSC) Appeals Division. The letter will tell you how to do this. Information is also below.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a STAR+PLUS service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, STAR+PLUS or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that STAR+PLUS usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and STAR+PLUS** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only STAR+PLUS, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
    - Authorize the medical care coverage **within 72 hours, or**

- Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**
- Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and STAR+PLUS

A Level 2 Appeal for services that STAR+PLUS usually covers is a State Fair Hearing with the Texas HHSC Fair Hearings Department. You must ask for a State Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a State Fair Hearing.

~~Mail your written request to:~~

Molina Healthcare of Texas
Attn: Member Inquiry Research and Resolution Unit
P.O. Box 182273

Chattanooga, TN 37422
Or
Fax to: (877) 816-6416

Or you can call Member Services at (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time. We can help you with this request. *If you need a fast decision because of your health, you should call Member Services to ask for an expedited Fair Hearing.*

The State Fair Hearings Officer gives you their decision in writing and explain the reasons.

- If the State Fair Hearings Officer says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Fair Hearings Officer says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for the requested service or item. This is called "upholding the decision"

If the State Fair Hearings Officer's decision is No for all or part of your request, you can request an Administrative Review within 30 days from the date of the decision. The Fair Hearings Officer's decision describes how to request an Administrative Review. An Administrative Review is completed by an Administrative Law Judge from the Texas HHSC Appeals Division.

Refer to **Section J** for more information about your appeal rights after Level 2 Appeal.

F5. Payment problems

We don't 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're never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for drug categories that require a copay.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send our share of the cost for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll 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 isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and STAR+PLUS usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that STAR+PLUS may cover. **This section only applies to Medicare Part D drug**

appeals. We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

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

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's *Drug List* or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination".**

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

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our *Drug List* or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our *Drug List*, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4**.	Refer to **Section G4**.	Refer to **Section G5**.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

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

> Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception".**

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

Covering a drug that isn't on our *Drug List*

- If we agree to make an exception and cover a drug that isn't on our Drug List, you pay the copay that applies to drugs in tier 5.

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our *Drug List* is in one of 6 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

- Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.

- If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
- If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.

- You can't ask us to change the cost-sharing tier for any drug in the Specialty tier.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

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

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling (866) 856-8699, TTY: 711, Monday – Friday, 8 a.m. to 8 p.m. local time, writing, or faxing us. You, your

representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.

- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

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

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling phone number, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
    - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
    - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says No to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.

- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:

  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Texas, the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) is Acentra Health. Call them at 1-888-315-0636. Contact information is also

in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO’s decision about your appeal.
- **If you don’t call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Information Counseling and Advocacy Program (HICAP) with Texas Department of Aging and Disability at 1-800-252-9240.-.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **“fast review”** is **“immediate review”** or **“expedited review.”**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that’s the right discharge date that’s medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at QIO toll-free phone number.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says Yes to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the Heath Information, Counseling, and Advocacy Program (HICAP) at 1-800-252-9240.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-315-0636.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.

- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says Yes to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says No to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional STAR+PLUS appeals

You also have more appeal rights if your appeal is about services or items that might be covered by STAR+PLUS. If you have questions about your additional appeal rights, you can call the HHSC Ombudsman's Office at 1-866-566-8989.

If you don’t agree with a decision given by the Fair Hearings officer, you may request an Administrative Review within 30 days of the date on the decision.

The letter you get from the HHSC Appeals Division will tell you what to do if you wish to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.

Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different **kinds** of complaints**.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the HHSC Ombudsman's Office at 1-866-566-8989.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at phone number. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's 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'll respond to your complaint in writing.
- Complaints are grievances that 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. Molina Medicare Complete Care Plus (HMO D-SNP) will complete the investigation as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days of receipt of the request, or within 24 hours for expedited grievances. Standard grievances must be responded to in writing. Grievances filed in writing must be responded to in writing. Grievances may be filed orally by

calling us at (866) 440-0012, TTY: 711, Monday– Friday, 8 a.m. to 8 p.m. local time; or in writing by mailing to: Molina Healthcare Attn: Appeals & Grievances P.O. Box 22816 Long Beach, CA 90801-9977, Fax: (562) 499-0610.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with Molina Medicare Complete Care Plus (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

STAR+PLUS

Once you have gone through the plan's complaint process, you can submit a complaint to the Texas Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can submit your complaint at: www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman/ombudsman-complaint-process

Office for Civil Rights **(OCR)**

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Call 1-888-388-6332, TTY: 1-877-432-7232.

You may also have rights under the Americans with Disability Act (ADA) and under Texas State Law. You can contact the Civil Rights Office of the Texas Health and Human Services Commission by e-mail at HHSCivilRightsOffice@hhsc.state.tx.us or by phone at 1-888-388-6332.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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 QIO, refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook*.

In Texas the BFCC-QIO is called Acentra. The phone number for Acentra is 1-888-315-0636.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and STAR+PLUS programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have STAR+PLUS you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for STAR+PLUS or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), the Health Information Counseling & Advocacy Program of Texas (HICAP) at 1-800-252-9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. TTY 711.

How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with 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 page number.

How to get Medicare and STAR+PLUS services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan. If you choose another Medicare plan that also provides your STAR+PLUS benefits, your STAR+PLUS plan will also change to the same plan that provides your Medicare benefits. You don't need to take any action for this to occur. **OR** You can enroll in the Program of All-Inclusive Care for the Elderly (PACE). PACE is available in Potter, Randall, El Paso, and Lubbock Counties. If you choose to enroll in PACE, the benefits include, but aren't limited to, all Medicaid and Medicare covered services including prescription drugs. You must receive all needed health care services, including primary care and specialist physician services (other than emergency services), from the PACE organization or an entity authorized by the PACE organization. • To get more information about PACE, call Texas PACE Program at 1-512-487-3450.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information regarding PACE provider enrollment and policy, you can contact the Texas Health and Human Services Commission (HHSC) at 512-487-3450. This number connects you with the Community Services Policy Unit, which oversees PACE operations in Texas. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-252-**9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. TTY 711. *In Texas, the SHIP is called* the **Health Information Counseling & Advocacy Program of Texas (HICAP).** For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. **OR** Enroll in a plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan. If you enroll in a new plan, you'll automatically be disenrolled from our plan when your new plan's coverage begins.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare drug plan. If you choose to move to Original Medicare, your STAR+PLUS plan will remain the same. You don't have to take any action for this to occur.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-252-**9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. *TTY phone number is optional*. *In Texas, the SHIP is called* the **Health Information Counseling & Advocacy Program of Texas (HICAP).** For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan for your Medicare benefits when your Original Medicare coverage begins, but you'll continue to be enrolled in our STAR+PLUS plan for your Medicaid benefits. You don't have to take any action for this to occur.

3. You can change to: Original Medicare without a separate Medicare drug plan. If you choose to move to Original Medicare, your STAR+PLUS plan will remain the same. You don't have to take any action for this to occur. **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop 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 the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-252-**9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. *In Texas, the SHIP is called* the **Health Information Counseling & Advocacy Program of Texas (HICAP).** For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins, but you'll continue to be enrolled in our STAR+PLUS plan for your Medicaid benefits. You don't have to take any action for this to occur.

4. You can change to: **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. If you choose another Medicare plan that also provides your STAR+PLUS benefits during certain times of the year, your STAR+PLUS plan will also change to the same plan that provides your Medicare benefits. You don't need to take any action for this to occur. If you choose to enroll in any other Medicare health plan, such as a Medicare Advantage Plan (MAP) or Original Medicare, during certain times of the year, then your STAR+PLUS plan will remain the same. In this situation, if you want to change your STAR+PLUS plan, you can change at any time by contacting the state Enrollment Broker 1-877-782-6440 or TTY: 711, 8:00 a.m. to 6:00 p.m. CST, Monday-Friday.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information regarding PACE provider enrollment and policy, you can contact the Texas Health and Human Services Commission (HHSC) at 512-487-3450. This number connects you with the Community Services Policy Unit which oversees PACE operations in Texas. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. *TTY phone number is optional*. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. If you choose another Medicare plan that also provides your STAR+PLUS benefits, you don't need to take any action for your

	STAR+PLUS plan to automatically align with your new Medicare plan. If you choose to enroll in any other Medicare health plan, such as a Medicare Advantage Plan (MAP) or Original Medicare, then your STAR+PLUS plan will remain the same. If you want to change your STAR+PLUS plan, you can change at any time by contacting the state Enrollment Broker 1-877-782-6440 or TTY: 711, 8:00 a.m. to 6:00 p.m. CST, Monday-Friday.

C2. Your STAR+PLUS services

For questions about how to get your STAR+PLUS services after you leave our plan, call the State enrollment broker at 1-877-782-6440 or TTY: 711, 8:00 a.m. to 6:00 p.m. CST, Monday-Friday. Ask how joining another plan or returning to Original Medicare affects how you get your STAR+PLUS coverage.

Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- **Use our network pharmacies** *including through our mail-order pharmacy services* **to get your prescriptions filled.**
- **If** you're **hospitalized on the day that your membership in** Molina Medicare Complete Care Plus (HMO D-SNP) **ends, our plan will cover your hospital stay until** you're **discharged.** This will happen even if your new health coverage begins before you're discharged.

Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you're away from our service area for more than six months. If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't 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 (CMS) notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's 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. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9 of this *Member Handbook* for information about how to make a complaint.

How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

E. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook*. The main laws that apply are federal laws about the Medicare and STAR+PLUS programs. Other federal and state laws may apply too.

F. Notice about nondiscrimination

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, or sexual orientation.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 1-888-388-6332 or 512-438-4313.
- 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.

G. Notice about Medicare as a second payer and STAR+PLUS as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to **members**. We take all reasonable measures to ensure that STAR+PLUS is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): **The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.**

Administrative law judge: **A judge that reviews a level 3 appeal.**

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."

AIDS drug assistance program (ADAP): **A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.**

Ambulatory surgical center: **A facility that provides outpatient surgery to patients who don't need hospital care and who aren't 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 of this *Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: **An all-inclusive term referring to mental health and substance use disorders.**

Biological Product: **A drug that‘s made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can’t be copied exactly, so alternative forms are called biosimilars. (See also “Original Biological Product” and “Biosimilar”).**

Biosimilar: **A biological product that’s very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to “Interchangeable Biosimilar”).**

Brand name drug: **A drug that’s made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.**

Catastrophic coverage stage: **The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on**

your behalf) have spent $2100 for Part D covered drugs during the year. You pay nothing.

Centers for Medicare & Medicaid Services (CMS): **The federal agency in charge of Medicare. Chapter 2 of this *Member Handbook* explains how to contact CMS.**

Clinical Research study: 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. Also called a clinical trial.

Community First Choice (CFC): Provides home and community-based attendant services and supports to Medicaid recipients with disabilities. A variety of services are included such as help with activities of daily living and health related tasks through hands on assistance, supervision or cueing, services to help the individual learn how to care for themselves, and training on how to select, manage and dismiss attendants.

Complaint: **A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".**

Comprehensive Health Risk Assessment: An assessment used to confirm your appropriate risk level and to develop your Plan of Care. Comprehensive Health Risk Assessments will include, but not be limited to, physical and behavioral health, social needs, functional

status, wellness and prevention domains, caregiver status and capabilities, as well as your preferences, strengths, and goals.

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.**

Consumer-Directed Services: **The member or his/her legal guardian is the employer of and keeps control over the hiring, management, and termination of a person providing personal assistance or respite.**

Copay: **A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.**

Cost-sharing: **Amounts you have to pay when you get certain drugs. Cost-sharing includes copays.**

Cost-sharing tier: **A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of six (6) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.**

Coverage decision: **A decision about what benefits we cover. This includes decisions about covered drugs and services or the**

amount we pay for your health services. Chapter 9 of this *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: **The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.**

Covered services: **The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.**

Cultural competence training: **Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.**

Daily cost- sharing rate: **A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you**

and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7-day supply of the drug, your payment is less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

Disenrollment: **The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).**

Drug management program (DMP): **A program that helps make sure members safely use prescription opioids and other frequently abused medications.**

Drug tiers: **Groups of drugs on our *Drug List*. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in one of six (6) tiers.**

Dual eligible special needs plan (D-SNP): **Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.**

Durable medical equipment (DME): **Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.**

Emergency: **A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an**

unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: **Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.**

Exception: **Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.**

Excluded Services: **Services that aren't covered by this health plan.**

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.

Financial Management Service Agency (FMSA): An organization that assists members and/or his/her legally authorized representative (LAR) in hiring or retaining Home and Community Based Service Providers

Generic drug: **A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.**

Grievance: **A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the**

quality of your care or the quality of service provided by your health plan.

Health plan: **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. All of them work together to provide the care you need.**

Health risk assessment (HRA): **A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.**

Home health aide: **A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't 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 been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.**

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

Independent review organization (IRO): **An independent organization hired by**

Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the Independent Review Entity.

Initial coverage stage: **The stage before your total Medicare Part D drug expenses reach $2100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.**

Inpatient: **A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.**

Integrated D-SNP: **A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.**

Interchangeable Biosimilar: **A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.**

List of Covered *Drugs* (*Drug List*): **A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary".**

Long-term services and supports (LTSS): **Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).**

Low-income subsidy (LIS): **Refer to "Extra Help"**

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 services and supports and medical costs.**

Medically Accepted Indication: Means the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

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 facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.**

Medicare: **The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").**

Medicare Advantage: **A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.**

Medicare Appeals Council (Council): **A council that reviews a level 4 appeal. The Council is part of the Federal government.**

Medicare-covered services: **Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.**

Medicare diabetes prevention program (MDPP): **A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.**

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 (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.**

Medicare Part C: **The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.**

Medicare Part D: **The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part**

A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: **Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.**

Medication Therapy Management (MTM): **A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to** Chapter 5 **of this *Member Handbook* for more information.**

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 explain your coverage, what we must do, your rights, and what you must do as a member of our plan.**

Member Services: **A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to Chapter 2 of this *Member Handbook* for more information about Member Services.**

Network pharmacy: **A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.**

Network provider: **"Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.**

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Non-Emergency Medical Transportation (NEMT): Non-Emergency transportation related services available under the Medicaid state plan. NEMT Services provide transportation to non-emergency health care appointments for members who have no other transportation options.

Nursing home or facility: **A place that provides care for people who can't get their care at home but don't need to be in the hospital.**

Occupational Therapy: Treatment that helps people who have physical or mental problems learn to do the activities of daily life.

Ombudsman: **An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information in Chapters 2 and 9 of this *Member Handbook*.**

Organization determination: **Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services.**

Organization determinations are called "coverage decisions". Chapter 9 of this *Member Handbook* explains coverage decisions.

Original Biological Product: **A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.**

Original Medicare (traditional Medicare or fee-for-service Medicare): **The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.**

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: **A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.**

Out-of-network provider **or** Out-of-network facility: **A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. Chapter 3 of this *Member Handbook* explains out-of-network providers or facilities.**

Out-of-pocket costs**: The cost- sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.**

Over-the-counter (OTC) drugs: **Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.**

Part A: **Refer to "Medicare Part A."**

Part B: **Refer to "Medicare Part B."**

Part C: **Refer to "Medicare Part C."**

Part D: **Refer to "Medicare Part D."**

Part D drugs: **Refer to "Medicare Part D drugs."**

Personal health information (also called Protected health information) (PHI): **Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.**

Plan of Care: A person-centered Plan of Care that addresses health care services you will get and how you will get them. The plan is developed by the Service Coordinator with you, your family, as appropriate, and your providers. The Plan of Care will contain your health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who will provide such services.

Physical Therapy: The treatment of disease, injury, or disability by physical and mechanical means. Post-Stabilization: Post-

stabilization services are services that keep your condition stable after emergency care.

Preventive services: **Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).**

Primary care provider (PCP): **The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.**

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): **An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.**

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): **A program that covers Medicare and Medicaid benefits together for people aged 55 and**

over who need a higher level of care to live at home.

Prosthetics and Orthotics: **Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.**

Quality improvement organization (QIO): **A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to Chapter 2 of this *Member Handbook* for information about the QIO.**

Quantity limits: **A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.**

Real Time Benefit Tool: **A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.**

Referral: **A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapters 3 and 4 of this *Member Handbook*.**

Rehabilitation services: **Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 of this *Member Handbook* to learn more about rehabilitation services.**

Service area: **A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.**

Service Coordination Team: A service coordination team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your service coordination team also helps you make a service plan.

Service 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.**

Service Plan: **A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.**

Share of cost: **The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.**

Skilled nursing facility (SNF): **A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.**

Skilled nursing facility (SNF) care: **Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing**

facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: **A doctor who provides health care for a specific disease or part of the body.**

STAR+PLUS: This is the name of Texas' Medicaid program. STAR+PLUS is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

It covers extra services and some drugs not covered by Medicare.

Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

State Hearing: **If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.**

Step therapy: **A coverage rule that requires you to try another drug before we cover the drug you ask for.**

Supplemental Security Income (SSI): **A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.**

Telehealth (Virtual Care): The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information

across distance.

Urgently needed care: **Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).**

Molina Medicare Complete Care Plus (HMO D-SNP) Member Services

Type	Details
CALL	(866) 856-8699 Calls to this number are free. Monday – Friday, 8 a.m. to 8 p.m. local time. Assistive technologies, including self-service and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays. **In Case of An Emergency:** Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP) or you may also contact our 24-Hour Nurse Advice Line at (888) 275-8750. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Monday – Friday, 8 a.m. to 8 p.m. local time.
WRITE	Member Services: Molina Medicare Complete Care Plus (HMO D-SNP) 2200 Highway 121, Suite 270A, Bedford, TX 76021
WEBSITE	MolinaHealthcare.com/Medicare